

A RETROSPECTIVE EVALUATION OF A NURSING RESEARCH AND
DEVELOPMENT PROGRAMME IN FINLAND

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PhD DEGREE
UNIVERSITY OF EDINBURGH
1990



Declaration

I certify that this thesis is my own work.

Acknowledgements

Many people have given their advice and support during the conduct of this study. My sincere gratitude goes to my supervisors Professor Penny Proffit and Dr Roger Davidson. Their interest and advice have been very important. I would like to acknowledge the contribution of various scholars with whom I have had useful discussions. I am grateful to Dr Ian Atkinson, Dr Larry B Briskman, Dr Katherine J Day, Dr Rolland Munro, Miss Moira Mugglestone and Dr Janette Webb. My debt to Dr Betty Farmer and Dr Susan Sladden is great for their social support. I am indebted to my Finnish colleagues Miss Ingrid Hämelin, Dr Kaisa Krause and Mrs Marjaana Pelkonen for reading my manuscript. I thank the Finnish Federation of Nurses for the financial support. Crucial to this project has been the support I have received from my family, my gratitude to my family is very great.

ABSTRACT

A Retrospective Evaluation of a Nursing Research and Development Programme in Finland

A Nursing Research and Development Programme was implemented in Finland in the years 1977-1983 as a part of the WHO Medium-Term Programme in Nursing/Midwifery in Europe. The purpose of the Nursing Programme was to develop health services through the development of nursing. The Programme was carried out under the auspices of the government authorities. The setting of research and development were health centres, hospitals and schools for health personnel. The Programme had key characteristics: (1) it integrated international and national discussion in nursing; (2) professional aspirations of nurses were confronted with the social realities; and (3) it provided the opportunity for simultaneous analysis of essential elements in nursing practice, education, research, and administration.

A retrospective evaluation was conducted to investigate: (1) the organizational characteristics of the Nursing Programme and how the organization supported the process of research and development; and (2) how nursing developed during the Programme and how the stated objectives of the Programme related to the actual outcomes. The study had two integrated components, namely the overall organization of the Programme and nursing as promoted through the Programme. Consequently, two conceptual perspectives and two evaluative perspectives were adopted for the study. The organization was analysed using four organizational metaphors: organization as a machine, as an organism, as a brain, and as political system. The evaluation strategy was composed of various models for programme evaluation. Nursing was analysed by employing the metaparadigm concepts man, environment, health, and nursing action, and evaluation was based on structure, process and outcome evaluation.

The archive of the Programme provided the major part of the data for the study. The following categories of material were employed: minutes, memoranda, plans, progress reports, educational material, letters, final reports, accounts, test nursing care plans, and patient/client questionnaires. In addition to the Programme archive, other archival sources and published material were used. The study was descriptive in nature and utilized qualitative methods, including content analysis for conceptual clarification and interviews in addition to analysis of multiple data sources.

The findings of the study revealed that the higher the level of an organizational element in the overall hierarchy of the Programme organization, the more mechanistic and political it was; whereas, the lower the level of an organizational element, the more organic and brain-like qualities were evidenced. Very minor support was received from the higher level of the Programme organization, and many obstructing acts were documented. Through education, consultation and information delivery provided by the Programme, the work of nurses was nurtured. In nursing practice, there was progress towards a humane, holistic, interactive, systematic and collaborative approach. It was demonstrated that the existing nursing resources can be employed in new ways. Research as an integral part of nursing began to evolve. It was shown that there is a need for further development in nursing education and administration.

Recommendations were made in regard to three aspects. In order to promote positive development in nursing it was recommended that leadership and professional communication will be fostered. In order to enable nurses to use their voice for the good of people, acquiring skills in understanding organizations and enhancing communication between the nursing profession and government authorities were proposed. For coordinated development in nursing, continuing education, research and administration as facilitators of the up-to-dateness of clinical nursing were recommended.

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1. Introduction

1.1. Prologue

The focus of this study was the evaluation of a Programme on nursing which as such had a limited timeframe but seen from the perspective of the nursing profession in Finland, the end was the beginning of something new. Exploration, learning and networking have continued. In this study, the Nursing Programme was approached with developing theoretical concepts if compared with the ideas which prevailed during the Programme. This was due to the international and national progress in nursing which provided a more coherent conceptual framework for analysis.

The purpose of this study was a comprehensive evaluation of the Nursing Research and Development Programme (hereafter referred to as the Nursing Programme) which was implemented in Finland in the years 1977 - 1983. The ultimate purpose of the Nursing Programme was to develop health services through the development of nursing. The project unified health centres, hospitals and schools to a workable network. The Nursing Programme was brought about due to the persistent pressure created by nurses in Finland and followed by government actions. Inherent in the Nursing Programme in Finland were views and goals shared by the European nursing community. This was due to the fact that the Nursing Programme in Finland was part of an international programme launched by the World Health Organization, Regional Office for Europe (EURO or WHO/EURO) and called a Medium-Term Programme in Nursing/Midwifery in Europe (1976-1983) (hereafter called European Programme). The European Programme in nursing was an extensive multinational project by which problems in nursing services, education and research identified by the Member States, were attempted to be solved through international collaboration. The Nursing Programme in Finland gained impetus from WHO/EURO while the European

Programme was in progression, and the Nursing Programme was planned and implemented under the auspices of government authorities in Finland.

Because of its origin and nature, the Nursing Programme provided: (1) an opportunity for the discussion of national and international issues in nursing; (2) a forum where professional ideals were confronted with the social reality (particularly with the health authorities); and, (3) the opportunity for simultaneous analysis of essential elements in professional nursing practice, education, research and administration. Thus, through its very nature, the Nursing Programme became part of a wider development in nursing in Europe. There were two basic assumptions which underlie this study. Firstly, the Nursing Programme was not an isolated event but part of a much broader historical movement in the profession of nursing. Secondly, it was assumed that it would be possible to extract from this study policy principles which could assist the profession of nursing to make an even more significant contribution to society in the future.

1.2. Background of the study

As a background to the study, both the European Programme and its origin as well as the emergence of the Nursing Programme and its salient features are introduced.

1.2.1. Roots of the Nursing Programme in the WHO/EURO

The WHO European Programme provided the stimulus for the national Nursing Programme. Therefore, the former actions of WHO/EURO and policy decisions of its Member States made in the Regional Committee (the major annual decision-making body on the regional level) formed the background to the Nursing Programme. Following a critical evaluation in the early seventies of the impact of WHO policies on the health programmes of Member States, it was concluded that the crisis intervention which had characterized WHO, had not provided sustained improvements in health care (WHO, 1977a). To prevent wasteful compartmentalization and the crisis intervention approach, more long-term

coordinated planning strategies were adopted by all departments of WHO. It was thought that the proposal for a European Programme would meet the identified needs for the development of nursing services in some Member States and the relevant government administrations were persuaded to support the initiative (Hämelin, 1989).

WHO functions by responding to requests for assistance with specific health problems reported by Member States. The contribution of WHO to the development of nursing services was considered at the time of the general scrutiny of the role and function of the Organization. This examination revealed a number of concerns within nursing. These were related to: (1) the overall function of nursing and nurses within health services, (2) the lack of nursing or shortage of nurses and weaknesses in manpower policy, (3) the lack of dynamic leadership in nursing and the use of outdated patterns in education and management and (4) the legislation which often prevented required developments. Consequently, as a response to requests from countries, a Medium-Term Programme in Nursing/Midwifery in Europe (1976-1983) was established by the Regional Committee in 1977 to further developments in the following major areas:

The nursing process: this term referred to the systematic mode of practice in which needs for nursing are assessed, nursing is planned and offered and the patient/client outcomes evaluated.

Organization and management of nursing/midwifery services: this area included, for example, patterns of delivery of nursing care, nursing personnel systems and the composition of roles and functions.

Education of nursing/midwifery personnel: basic, postbasic, advanced, inservice and continuing education programmes were parts of this area.

Resource planning: this term referred both to human and material resources be they nurses, information, or equipment.

Based on the European discussions conducted at various WHO regional meetings, there was also a belief that on the positive side, there was not only a general

recognition of basic problems but also a willingness to deal with them. There was also evidence to suggest that in the European nursing community motivation and intellectual capabilities were available to permit developments in nursing (WHO, 1976). The situation was summarized in the document on which the European Programme was based:

In the European Region attention has been increasingly focused in recent years on problems related to the real function of the nursing discipline within overall health services and its role in the determination, provision and evaluation of care services in all phases of health and sickness. (WHO, 1977a, p 1)

Before that point and also thereafter the European Programme was developed through a series of meetings and consultations by which advice was widely sought from nurses and related professionals. The European Programme may be further characterized by its objectives and its structure. It was stressed that the European Programme was 'not an end in itself but rather a means whereby national and, in some instances, multinational activities could be stimulated, supported, strengthened and coordinated' (WHO, 1977a, p 2). In that spirit, the objectives of the European Programme were: (1) to support countries in developing nursing administration within the health service system, (2) to advance nursing input especially into the European priority areas, which were primary health care, health care of the elderly, mental health, maternal and child health and prevention, control and treatment of communicable and chronic diseases, (3) to advance nursing research and education and (4) to coordinate the efforts in nursing development (WHO, 1977a).

For the purpose of the European Programme, a terminology was developed which indicated how its key elements were defined. The following Exhibit 1.1. introduces the major terms employed in the European Programme and in the Nursing Programme.

EURO World Health Organization (WHO), Regional Office for Europe

Other country networks were developed for extending participation to countries not having designated Collaborating Centres.

Collaborating Centre Institute that possessed necessary expertise and facilities to fulfil range of functions related to the WHO research programme.

Type I Participating Centres 'Centres formally associated with the programme and agreeing to participate in the multi-national studies using standard research instruments. Such centres should also agree, as part of the study, to experiment with alternative patterns in the organization and management of nursing services.'

Type II Participating Centres 'Centres formally associated with the programme and agreeing to experiment with the provision of nursing care using the nursing process method as outlined in the medium-term programme in nursing/midwifery in Europe.'

Type III Participating Centres 'Centres formally associating themselves with the programme and wishing to be kept informed on a regular and supplementary basis of programme development. Such centres would also agree to inform the Regional Office of the results of the use of programme concepts or methodologies.' (WHO/EURO/NURS/ 80.1. pp 4-5)

Exhibit 1.1. Key terminology of the European Programme (WHO, 1980a)

Through the European Programme, greater opportunities were sought to further nursing. This was stated in the report on a WHO meeting held in Kiel in 1974:

Emphasis was placed on the importance of work at national level. Countries participating in the programme would first of all be taking action on aspects relevant to their own problems ... What was evident was that many problems were of common concern on an inter-country basis. There was scope for exchange of information, knowledge, experience and ideas and in some instances for co-ordinated activities. (WHO, 1974b, p 6)

The emphasis on extensive and active involvement at the national level, supported by the international network, produced the overall structure of the European Programme. This structural idea also brought resources to the European Programme. The elements defined in Exhibit 1.1. formed a structural model of the European Programme. The structural model was utilized in the participating countries and it is shown in Figure 1.1.

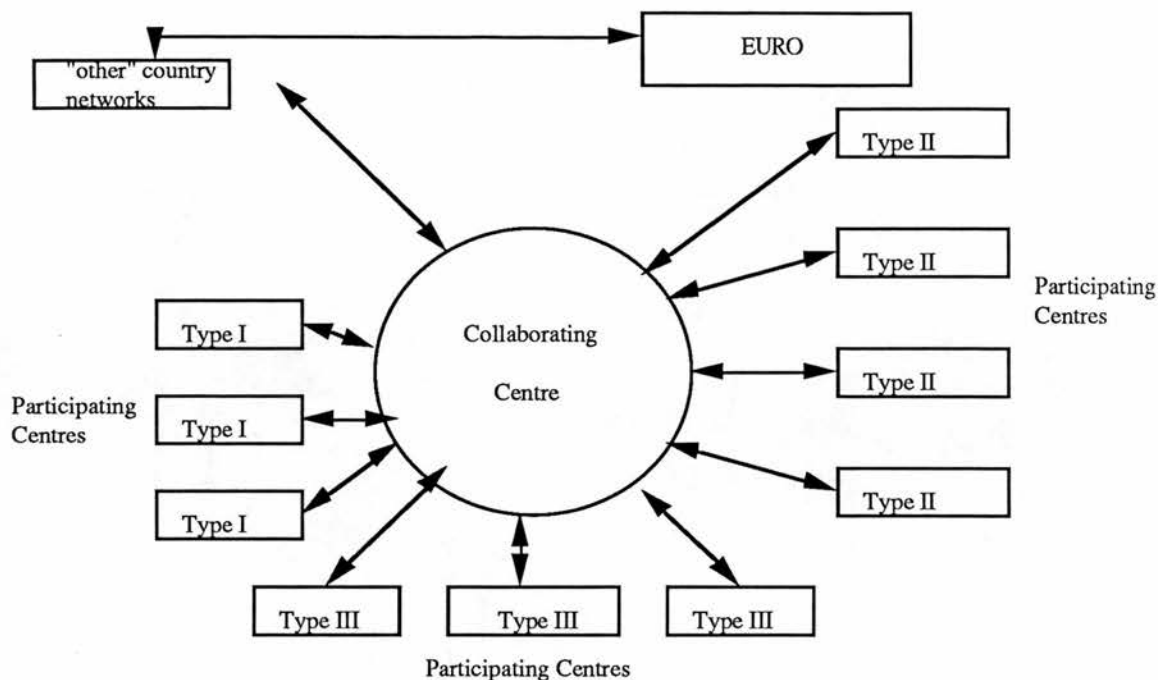


Figure 1.1. A model of a system at country level Source: Medium-Term Programme in Nursing/Midwifery in Europe. Information on Collaborating and Participating Centres. (EURO/Nurs(80.1,15 March 1980, (WHO, 1980a) with permission of the Nursing Unit, WHO Regional Office for Europe)

The implementation of the European Programme required the establishment and smooth running of the structure featured in Figure 1.1. The staff of the Nursing Unit in the WHO Regional Office had the overall coordinating and supporting role. For the first time in the history of WHO, eight Collaborating Centres in nursing were designated. These centers were created in Belgium, Denmark, England, Finland, France, Poland, Scotland and Yugoslavia. Each Centre appointed a nurse researcher (called a Programme Manager) who was responsible for planning and conducting the Multinational Nursing Study and for implementing the European Programme on national level. Primary health care institutions, hospitals and nursing schools were recruited to become Type I, Type II and/or Type III Participating Centres. This recruitment was done by the country contact persons - in Collaborating Centres, Programme Managers - with the support of the secretariat of the WHO/EURO Nursing Unit. The principal function of the staff working within the Collaborating Centres and in Type I Centres was to conduct a Multinational Nursing Study in the context of the nursing process. The staff working in the centres were supported by several international nurse consultants throughout the planning and conduct of the study.

This Multinational Nursing Study of People's Needs for Nursing Care (WHO, 1987) was an important joint effort of many practicing nurses and nurse researchers. The process of that study influenced all other activities of the European Programme. The broad aims of the European Study were:

- to develop research expertise among nurses and to support nursing research within countries;
- to increase knowledge about the nursing care needs of selected groups of patients, the care planned to meet those needs and the outcomes of the care given;
- to develop a network of centres so as to achieve the above two aims, and to encourage communication within and among Member States on nursing care practices and research and related educational activities;
- to promote the development of nursing as a discipline within European countries through further application of the nursing process. (WHO, 1987, pp 4-5)

During the European Programme, Collaborating Centres developed important roles in respective countries, acting as a focal point for the national developments (e.g. Pflegeforschung für eine bessere Krankenpflege, 1986). To facilitate the coordinated and goal-focussed efforts, communication links were established between the WHO/EURO and the Centres .

In summary, the European Programme focussed on four areas: the nursing process, organization and management of nursing services, education of nursing personnel and resource planning. Its structure included three types of Participating Centres, eight Collaborating Centres and the Nursing Unit at the Regional Office. Through the network of centres, a true participation was sought and a real opportunity was offered to the European nursing community for channeling the innovative energy and for working together. As a part of the European Programme, the Multinational Nursing Study was launched.

1.2.2. The Nursing Programme in Finland

Nurses in Finland were informed about the WHO European Programme primarily through the report of the planning meeting held in Kiel (WHO, 1974b). The report included strategic facts about the content and structure of the European Programme which enabled representatives of Member States to consider the possibilities of active participation in the European Programme. As an annex of the report, there was A Position Paper on Nursing (Hall, 1974). This paper re-stated the nature and purpose of nursing relative to current and prospective social changes, and it became an important background document in the national Nursing Programme. One of the basic assumptions of Hall - and significant in the Finnish context - was:

Nursing, as a profession in its own right and a discrete health discipline, is responsible for planning, organizing, implementing and evaluating nursing services as a distinct segment of health care, and for educating practitioners to provide these services. (Hall, 1974, p 1)

The European situation in nursing was applicable to Finland. Similar concerns and problems were identified on national level, such as a lack of understanding of the contribution of nursing to the total health services, scarcity of research in nursing, and outdated management patterns. Typical to Finland was also the existence of a wide awareness among nurses of the need for change.

A letter from the Regional Director of WHO/EURO to the government of Finland at the end of 1974, initiated the formal process towards the full participation in the European Programme. The letter introduced the European Programme and invited a declaration of interest in active participation. Nurses in Finland were consulted about the WHO offer through the National Board of Health. The nursing community gave priority to the nursing process and nursing education areas, when the Ministry of Social Affairs and Health was interested in nursing education and organization and management of nursing services. In March 1975 the Ministry formally declared its intention to participate in the European Programme. Two years later, the Ministry of Social Affairs and Health took the first concrete action within the European Programme by establishing a Coordinating Committee for planning and coordination of the national activities. This was the formal start of the

Nursing Research and Development Programme in Finland. In October of the same year (1977) a nurse was employed as the first and the only full-time worker for the national Programme. That person acted first as a member of the Coordinating Committee, then as a planner, and during the Programme implementation as Programme Manager according to the EURO terminology. As Programme Manager I worked both for the national Programme and for the Multinational Nursing Study. The latter part of the role became more prominent when the Nursing Research Institute in Finland was designated as a WHO Collaborating Centre in 1979. This arrangement provided the opportunity to link the international and national parts of the European Programme.

According to the official categorization of the research activity in Finland 'by research and development, a reference is made to systematic actions geared towards increasing knowledge and to utilizing this knowledge for finding new applications' (Research activity, 1977, p 52). This statement about research and development was applied in the Nursing Programme. The Programme was implemented under the auspices of the National Board of Health, and the Centre for the Nursing Programme was located in that office. The Board established a Consultative Committee for the Nursing Programme, and the Committee in turn set up a Project Group which functioned as a task force of the Consultative Committee. It was the master plan for the Nursing Programme, published by the Ministry of Social Affairs and Health, which for the first time officially introduced the Finnish translation of the word 'nursing' which is 'hoitotyö'.

As the European Programme required the involvement of the Member States at the regional level, it was understood that the philosophy of its implementation at the national level required the participation of the actual nursing settings. Therefore, the primary health care centres (called also health centres) and hospitals were recruited to participate in the effort as Type I and Type II Centres. Decisions on participation were made by the governing bodies in respective health care settings. Schools for health personnel (in this text their nursing departments are called nursing schools) were also encouraged to participate. The opportunity to become a Type III Participating Centre and receive information regularly about the progress of the Nursing Programme was offered to all health centres and schools outside the active Programme, and to the majority of the hospitals (the decision was made

not to include very small and atypical hospitals). The size of the Nursing Programme indicated by the number of Participating Centres is presented in the following table.

Type of the Centre	Number of the Centres
Type I Participating Centres for conducting the Multinational Nursing Study	4
Type II Participating Centres active in the Nursing Programme with 39 sub-programmes which were clinical or educational in nature	22
Type III Participating Centres in the information network	140

Table 1.1. Type and number of Participating Centres in the Nursing Programme

This meant that the whole system described previously (cf. Figure 1.1.), was in operation in Finland. From the beginning, midwifery was included as an integral part of the Nursing Programme. The actual work in Type II centres and the research and development projects covered wide areas of nursing.

For the purposes of the Nursing Programme, no new definitions of nursing were provided. It was agreed that Henderson's classic definition could be accepted by active participants.

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. (Henderson, 1969, p 15)

This definition brings into the nursing domain matters of health and illness and the ever changing needs of people.

The overall goal of the Nursing Programme was to increase knowledge about nursing and to develop nursing as an integral part of the health service system. The

objectives of the overall Nursing Programme were documented in detail in the following manner:

To develop the body of knowledge and technology of nursing through multidisciplinary research by producing tested functional models and methods of nursing within the priority fields of health services policy.

To develop concepts and terminology of nursing and to achieve greater uniformity in regard to them.

To improve and strengthen nursing administration and management at all levels of the health services system.

To disseminate knowledge, acquired through research in the nursing process and through international collaboration in the field, - into the changing field of nursing education and into nursing practice.

To promote and develop a rational system of nursing personnel (nurse manpower planning system).

To build into health services, research and education a continuing strategy for the development of nursing.
(The master plan for the Nursing Programme, 1978, p 17)

Before the details of the Nursing Programme were introduced to the nurses, a baseline study was conducted in 20 Participating Centres, both Type I and Type II centres participating voluntarily. The following topics were looked at in that study: nursing as documented in the patient/client records; evaluation of nursing procedures; affective and cognitive domains in nursing and interpersonal skills of personnel; patient/client expectations concerning care and their readiness to participate in their own care.

Basic methods employed to initiate the Nursing Programme in Finland and to maintain its progress were: (1) education and training, (2) consultation and (3) information delivery. Those were the activities of the Centre of the Nursing Programme along with the Project Group. The Nursing Programme yielded a great variety of documents including: overall plans and annual plans; minutes and memoranda; progress reports and letters; and final accounts and data collected for

evaluation purposes. These documents and the data have been used in the evaluation of the Nursing Programme in Finland.

The Nursing Programme in Finland was intended to provide a framework within which nursing could be promoted as a distinct element of the health care system and as a unique service to people. It was of great interest that the authority of WHO mobilized the health authorities to further nursing. National and international forces were brought together, so also were government and professional interests. Long-matured professional ideas and government actions seemed to cross and to meet. Pressure for change came at the same time from the international and national nursing community. Furthermore, the European Programme with its overall content and its multinational research project provided sufficient perspective for multi-faceted exploration and collaboration in nursing matters. Great expectations were attached to the Nursing Programme by the Finnish nurses themselves.

Up to this point in this sub-section, two slightly different though integrated components of the national project have been outlined. Firstly, the national committees and the task force along with the network of Participating Centres formed the overall organization working towards the purpose of the Nursing Programme. Secondly, the implementation of the Nursing Programme in health centres and hospitals was essentially clinical and also in nursing schools the nursing perspective prevailed. In this study, those two components - the overall organizational perspective and the essentially nursing perspective - and their interplay, formed important determinants.

In summary, the Finnish programme involved altogether 166 schools, health centres and hospitals as Participating Centres, and the Nursing Research Institute in Helsinki as a Collaborating Centre. The planning of the national programme took place under the auspices of the Ministry of Social Affairs and Health whereas the implementation was coordinated by the National Board of Health.

1.3. The research questions

The development in the Collaborating Centre and in Type II Centres indicated the catalyst function of the Nursing Programme. Through their services, Type II Centres reached a wide nursing clientele. Initiation and maintenance of the Nursing Programme was a considerable national effort, and it had many facets: political and professional; scientific and clinical; international and national. In the light of previous discussion, the evaluation of the Nursing Programme is appropriate and of significance for further developments in nursing in Finland.

The ultimate purpose of the Nursing Programme was to further health services through the development of nursing. The purpose of this study was a comprehensive evaluation of the Nursing Programme with a focus on the two integrated components of the national project: those of the overall organizational element and the clinical element. The study addressed the following research questions:

1. What were the organizational characteristics of the Nursing Programme?
2. In what ways did the organization of the Nursing Programme support the process of the research and development?
3. What were the characteristics of nursing in clinical settings at the completion of the Nursing Programme?
4. How did the stated objectives of the Nursing Programme relate to the actual outcomes?

In answering these questions, a research strategy was employed which utilized: (1) an outline of the development of the discipline and profession of nursing, (2) a conceptual framework both for the organizational analysis and the analysis of nursing and (3) an evaluation approach.

1.4. Significance of the study

There are three broad categories of reasons which justify this study. They are related firstly to the purpose of nursing in society, secondly to the unique nature of the Nursing Programme, and thirdly to the potential of the evaluation to develop future nursing policy.

The purpose of nursing in society is to contribute to the health and well-being of people. Because needs for nursing are changing when the society is changing, constant research activity is required to monitor the response of nursing to people's needs. In this study, the concerns and problems recognized in nursing and nursing strategies developed to meet the challenges will be analysed. On the basis of the analysis it will be possible to formulate suggestions for nursing practice. It will be shown as well, how certain key concepts in the discipline of nursing have found practical applications; among those concepts are 'man', 'health', 'environment' and 'nursing process'. These are concepts with wide theoretical and practical relevance (Fawcett, 1984; Meleis, 1985; Yura & Walsh, 1988).

The Nursing Programme was a major effort and a quite unique project in combining the work of individual nurses with the efforts of the international health authority. The Programme mobilized a large group of nurses and created a means for using their potential. However, the nature of the established organization, its typical processes, and the outcomes of the Nursing Programme have not yet been evaluated. It is expected that the findings of the study will give some indication of the utility of this kind of effort as a vehicle for the further development of nursing.

Much of the European development in nursing today, and as it is believed national development, is due to the experience gained in the European and national Nursing Programme. Improved understanding of the processes like the Nursing Programme may be beneficial for the future of nursing. It is believed that this study will assist in shaping future policies for nursing in regard to the internal and external interventions which will be made by nurses. It is also believed, that both

the organizational analysis and the evaluative approach may turn out to be useful assets for nursing generally and as research approaches specifically.

1.5. Nursing and health services in Finland

The European Programme called for national activities which inevitably were dependent on national traditions, conditions, and resources. Therefore, the utilization of the European Programme and the final content of the Nursing Programme in Finland can be understood against the national background. This section includes brief descriptions of nursing and health services in Finland.

1.5.1. Nursing in Finland

Nursing in Finland can be described within the following framework: nursing as part of social development; the health service system generally, and particularly hospitals as a scene of the development; a philosophy of nursing education; the manner in which nurses organize their work; and the international aspect.

There are in a sense two separate roots recognizable in Finnish nursing. In the care of the sick, especially in institutions, a casual labour force was needed for domestic functions and for basic physical care. For these purposes untrained men and women were employed. Only gradually, as a reflection of the general development of hospital care, training of those workers became necessary, and that led to nursing education (Tuulio, 1948). The other root brought life to the early phases of nursing from abroad, particularly from Britain but also from the USA. An important historical figure, Baroness Sophie Mannerheim, received her nursing education at St Thomas's Hospital (Pohjala, 1965; Tuulio, 1948), and a quite rapid development took place in Finland under her leadership.

As is natural, the most important single feature influencing nursing, has been the general social development. Values held in society, the expressed needs of people,

and resources made available, have step by step given form to health services and to nursing. Only seldom, and probably only in the case of public health nursing in 1940 - 1950, has nursing taken a lead in developing health services. Officially, only numbers of nurses and categories of nurses have been dealt with in policy and planning documents; nursing as such has never been given any purpose or content in health care. Nursing conceptually and practicewise has been cherished only by nurses themselves. No legislation referring specifically to nursing exists.

Technological advances in medicine and related hospital care have influenced nursing services in several ways: in patterns of specialization; in creation of new roles with a narrow scope of practice (e.g. infarction nurse, diabetes nurse etc.); and quite strict confinement within the hospital walls. After the Primary Health Care Act in 1972, the comprehensive nature of community nursing was changed by outside forces, and specialization according to age groups and workplaces became dominant. The administrative model both in health centres and in hospitals is hierarchical, and the model does not assume much professional authority of nurses on the level of direct patient/client care.

Because nursing has not been recognized as an identifiable and unique part of health services, impetus for its change or development has come through education or from overall health policy. The majority of government interventions have been focused on education, and that has taken place in committees established by government authorities. Since 1929 nursing schools have been independent of service institutions (Pohjala, 1965). Thus, though it has not been possible to discuss nursing, it has been possible to discuss how nurses might be trained and how many nurses should be available. In other words, through structural educational changes mainly, change has been introduced to nursing, and sometimes (as in the case of the Primary Health Care Act) major health policy decisions have affected nursing. It is not argued here that changes in society should not have an impact on nursing. It is contended that these kinds of factors have led to development which has not been progressive, smooth and controlled.

The general pattern in the nursing education system has been threefold: (1) basic education leading to registration as a nurse; (2) specialization for several areas in

institutional care (midwifery and gynecological nursing, pediatric, medical, surgical, psychiatric, anesthesiological and operating theatre nursing) and community; and, (3) advanced education for teaching and management. The educational authorities decided to remove the third level of education into universities. This process is presently taking place. The other trend in nursing education is the abandoning of the nurse generalist type of education and combining of basic and specialized education which along with some other changes has been perceived by the profession of nursing to lower the level of education (Suomen sairaanhoitajaliitto, 1987). Nursing education takes place in schools for health personnel, which are totally outside the main stream of academic education. In universities, nurses are learning their teaching and management skills together with all paramedical groups, following the same programme. These changes in the educational system are apparently widening the gap between theory and practice in nursing.

The way nursing resources have been deployed can be described as a continuum from task allocation to individualized nursing. The dominant patterns of work organization in nursing have been task allocation and team nursing (with clear task allocation within that framework), normally with a professional nurse (i.e. a first level nurse) as a group leader. The tendency has been to leave direct nursing to the least educated members of the team, and more educated nurses have been concerned with paperwork and assisting physicians (Suomen sairaanhoitajaliitto, 1987). However, in recent years primary nursing¹, within which one nurse is accountable for comprehensive nursing care of an individual through the whole hospital stay, has called forth much interest, and in public health nursing, community based practice has become a goal (Ministry of Social Affairs and Health, 1987). By community based practice a reference is made to work organization whereby a nurse is providing comprehensive nursing services to a population living in a certain geographic area, and when fully implemented it would mean 'community as a client' approach.

¹ Primary nursing is both philosophy and a design of work. It includes the following main elements: a primary nurse assumes accountability for nursing care of a patient 24 hours a day; a primary nurse has the autonomy for making decisions on patient care; nursing care is coordinated by a primary nurse, assisted by an associate nurse, and reported directly from nurse to nurse; a primary nurse provides comprehensive care to primary patient(s) (Hegyvary, 1982).

By the early seventies, the nursing community in Finland had created a kind of informal network for discussion on matters of common interest among nurses in practice, education and administration. Issues related to nursing practice, research and higher education were dealt with intensively. As a result of that attempt, some conceptual clarity, an awareness of existing problems, and some elementary ideas about the strategy to overcome the problems were reached (Sorvettula, 1984). This historical phase is considered to have been an important prerequisite for the development which took place in relation to the European Programme in nursing, and which finally made international collaboration an important factor. It is believed that to some extent, factors described in this paragraph gave birth to the professional undercurrent which was the source of strength in further developments. It is also believed that the awareness and the readiness of the nursing profession explain why the catalytic role of the WHO European Programme was easily accepted. The development which followed was unique in Europe. The fifth characteristic in Finnish nursing has, therefore, been participation in the developments in nursing internationally. Apart from very short periods in its history, Finnish nursing has maintained active relationships with colleagues abroad (Sairaanhoidon Tutkimuslaitos, 1982). This tradition, together with the increased awareness of social forces requiring change in nursing, led nurses to follow keenly the growth of the WHO activities for the development of European nursing.

In summary, nursing in Finland has developed in interaction with the general developments of the health services. However, decisions made in the educational system have greatly shaped nursing. This seems due to the fact that health authorities recognize nurses but not nursing. Major changes in nursing education have moved management and teacher training into universities and emphasized specialization in basic education. It has been characteristic of Finnish nurses to follow and learn from international nursing. As a result of that interest, supported by national efforts, awareness was created among nurses about key issues in the profession.

1.5.2. Health service system in Finland

The development of Finnish health policy after the Second World War can be described in five phases:

Phase 1 (the 1940's) Maternal and child health care was developed, and this period gave birth to community nursing (public health nursing) as an organized service.

Phase 2 (the 1950's) The national hospital network was built up and Finland achieved an international standard of specialized hospitals, but as the resources went mainly to the hospital sector, this created an imbalance in health development; as the focus was on the hospital sector the non-hospital sector was neglected.

Phase 3 (the 1960's) Finland established the National Sickness Insurance Scheme as a remedy for the high costs of outpatient services, expensive medicines and lack of income security during illness.

Phase 4 (the 1970's) After those national efforts, about 90% of the public health resources were spent on specialized medical care and the rest on primary health care; however, the health indicators showed slow progress except in infant mortality; inadequacy of primary health care services was diagnosed as a main reason for the situation, and so the 1970's became the decade of the Primary Health Care Act which instituted primary health care services as well as a five-year rotating planning system.

Phase 5 (the 1980's) Integration of health and social welfare services has been a characteristic of this decade. The philosophy and strategy of 'Health for All by the Year 2000' has been an important determinant of the health policy since the International Conference on Primary Health Care held in Alma-Ata in 1978 (Ministry of Social Affairs and Health, 1987; Puro, 1988).

Access to health care is a right of every citizen, and it is the responsibility of the local authorities to make services available according to the needs of the

inhabitants. Though this principle of local responsibility is an essential one, government control comes into the picture through a rotating five-year plan. For comprehensive and equitable development, State subsidies to municipalities are dependent on the congruence of the local and national plans.

Primary health care is provided by health centres (N=213). The main functions of these centres are: (1) maternal and child health services; school health and occupational health services mainly for small enterprises, (2) health education; and birth control guidance, (3) preventive and curative outpatient services of general practitioners; general practitioner hospital care mainly for the chronically ill elderly, domiciliary nursing; and ambulance services, (4) dental services, especially for youth, and (5) local control of environmental health factors (Puro, 1988).

For specialist treatment, the country has been divided into 21 central hospital districts which are run by federations of communes. The most common medical specialities are represented in each hospital. Five of those central hospitals are university teaching hospitals which also provide rarer medical specialist facilities. Complementary to that basic network of hospital services, there are regional and local hospitals run by smaller federations of communes. These institutions can be found in big cities or in towns at some distance from general hospitals. There has been a separate network of mental hospitals and of T.B. sanatoria, both of which are run by municipalities. Presently there is a process going on whereby those three separate networks mentioned will be integrated into comprehensive hospital districts. The infrastructure of the Finnish health service was of great significance and provided a good starting point for the focused development of nursing. The organization of the Finnish national health services is described in the following figure (Figure 1.2.).

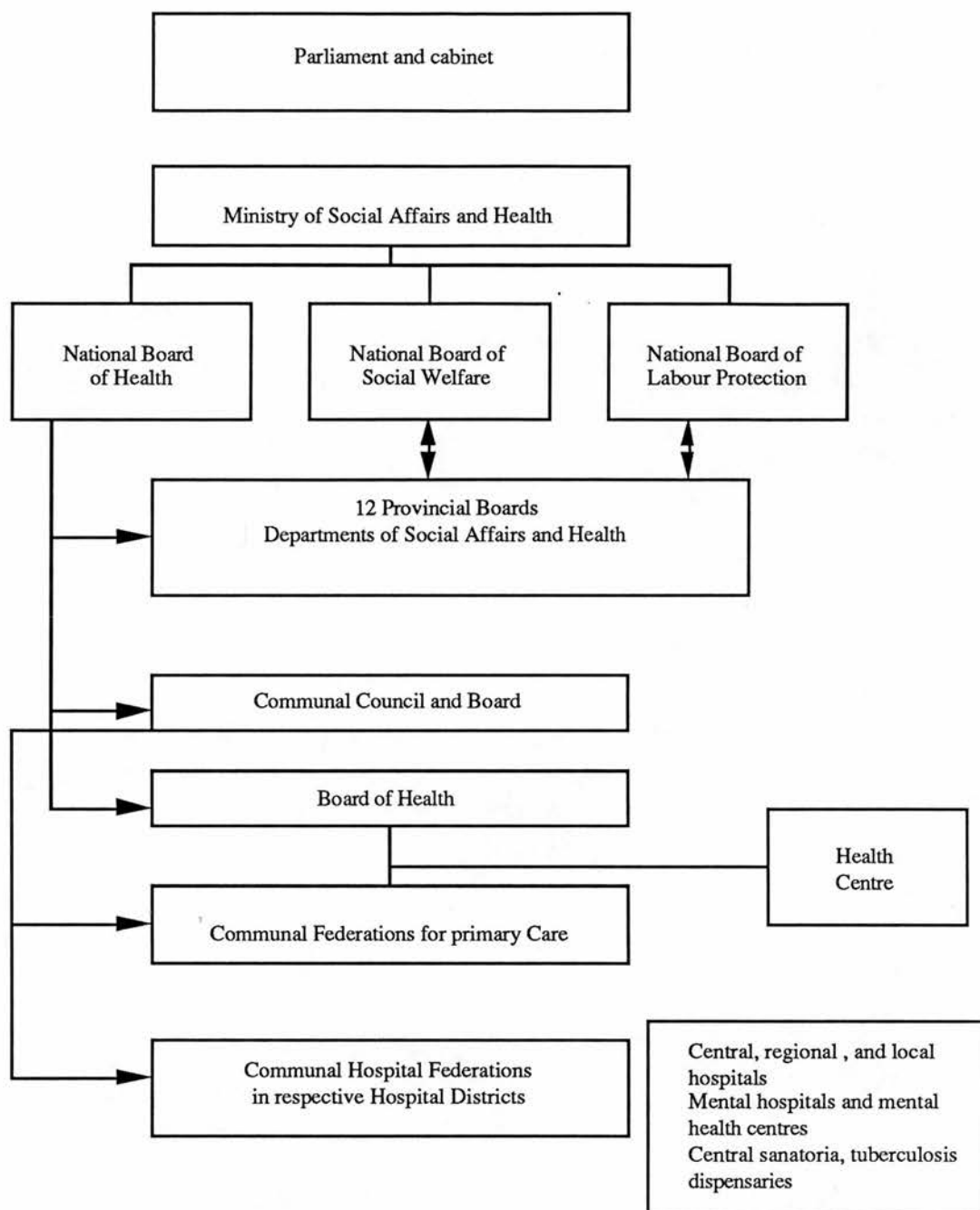


Figure 1.2. Organization of the Finnish National Health Services (Adapted from the Yearbook of the National Board of Health 1981-1982)

The general goals of the five-year plans for primary health care and hospitals are perceived to represent the core of the contemporary health policy. They inevitably constitute a very important set of criteria against which developments in nursing could be compared. The goals had a cumulative structure: prior goals were repeated until they were reached, and new goals were added when required. The following table is a synopsis of the goals for the years 1976-1983.

Goals for health centres	Goals for hospitals
To intensify the organizing and planning of prevention, treatment and rehabilitation of major common diseases.	To enhance health services (by developing especially outpatient care) and rehabilitation services in hospitals -health education included - and specialist medical consultation services in health centres.
To enhance basic health services, especially outpatient health services, long-term care and occupational health services.	To safeguard treatment of most common diseases to all in need.
To decrease regional differences in the delivery of services.	To decrease regional differences in the delivery of services.
To develop the progression of services and the appropriateness of the content of different services and methods used.	To develop cooperation between hospitals, and between hospitals and health centres, as well as appropriate distribution of work on different levels of the system.
To develop the monitoring of the efficiency as well as the economy of primary health care.	To organize the monitoring of the efficiency of hospitals as well as the economic monitoring.
To improve the efficacy and efficiency of activities.	To improve the efficacy of activities.
To develop health education (for lifestyle conducive to health) and patient teaching.	To develop health education and patient teaching.
To intensify cooperation with other health care agencies and social services.	To intensify cooperation with other health care agencies and social services.

Table 1.2. General goals of five-year plans for health centres and hospitals for the years 1976-1983 Summarized from the national five-year plans

In summary, since the Second World War Finland has gradually developed its health service system to include primary health care services, sickness insurance, and specialized hospital services. During the last ten years, special emphasis has

been put on the integration of the 'Health for All' philosophy and strategy in the existing policy.

1.6. 'Health for All by the Year 2000' as a coexistent WHO programme

Impetus for change in European nursing came also from the major development in WHO that of 'Health for All by the Year 2000' (HFA or HFA/2000) which was parallel to the European Programme. The achievements in nursing inevitably have to be discussed in the light of that health philosophy. Therefore, 'Health for All' will be briefly introduced in this section.

This global health movement has its roots in the World Health Assembly which in 1977 resolved that 'the main social target of governments and of WHO in the coming decades should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life' (WHO/HQ, 1981, p 15). The International Conference on Primary Health Care held in Alma-Ata in 1978 further developed the global goal by declaring that the key to Health for All is primary health care. In the Declaration of Alma-Ata the traditional WHO definition of health was repeated:

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. (WHO/UNICEF, 1978, p 2)

Primary health care is a first level contact point to the national health service system which is near to people, is socially acceptable and accessible to them, and includes the provision of promotive, preventive, curative, and rehabilitative services. Primary health care is supported by the referral system which means that secondary and tertiary level care have been accorded new positions in the overall health service system.

As a philosophy, 'Health for All' includes values of social justice and equity, and it gives great significance to self-reliance and self-determination of people and their right and duty to participate in planning and implementation of health care. As a strategy, 'Health for All' is a comprehensive process directed towards the better health of all people. In regional or national implementation particular cultural, economic, and social factors will shape the HFA/2000 process. According to the documents produced as a result of international exploration and debate, this health movement is not meant to be stereotypical in national applications. The 'Health for All' strategy calls for support of self-care of the individuals, multisectoral cooperation, multidisciplinary collaboration, scientifically sound practices, and the fullest possible use of available resources. More precisely, the European strategy consists of the following three elements: (1) promotion of healthy lifestyles, (2) reduction of preventable conditions and (3) provision of adequate and accessible health care for all (WHO/UNICEF, 1978; WHO/HQ, 1981; WHO, 1981). Targets for health for all, the European document (WHO, 1986), further clarified the direction of the European health development with its 38 concrete health targets. These targets are followed by an analysis of the underlying problem and suggested solutions, and they cover the following areas: general health improvements, lifestyles conducive to health, healthy environment, appropriate care, research in support of health for all, and health development support measures.

A workshop on 'The role of nursing in primary health care', jointly sponsored by the International Council of Nurses and the World Health Organization (Headquarters, WHO/HQ) began explorations of this new health philosophy in the nursing community in 1979 (ICN/WHO/HQ, 1979). In 1981 another global meeting was convened by the WHO/HQ. This meeting pointed out the necessary strategies for change required in nursing which would enable it to become a force for the HFA movement. Those strategies were related to research, education, contribution of nursing to policy-making, and leadership (WHO/HQ, 1982). After the completion of the European Programme, the HFA/2000 movement has continued to grow, and nurses have continued to take an active part in that process (WHO, 1988).

There are several reasons why the 'Health for All' philosophy and strategy have close connections with nursing. The prime characteristic of nursing is its interest in the human being, in his or her overall good as it relates to health and illness, coping with physical and emotional self, or with practicalities in everyday life. According to the HFA goals, all human beings of the world should attain a level of health which 'will permit them to lead a socially and economically productive life'. At the heart of nursing there is the same ideal as exemplified by the widely used definition by Henderson (1969) which originated in the fifties and comes very close to the concept of lifestyle conducive to health and the kind of support people will need in adopting such a lifestyle.

Health is the other concept which is found both in the intellectual history of nursing, and in nursing practice as a guiding principle. Community health nursing, which has included health promotion and prevention as its integral parts, has been perceived to be an essential branch in nursing practice. In hospitals and other institutions, nursing has been offered particularly to those who are ill, suffering or dying. However, while nurses will attend to the illness-related matters, they will also attempt to build on existing strengths, i.e. on the existing health potential. HFA/2000 philosophy does not require any major changes in the orientation of nursing. Quite the contrary: the global health movement gives a positive impetus to nursing to realize more widely its deeply held beliefs. The best single example of advanced thinking in nursing may be the Report of a WHO Expert Committee on Community Health Nursing (1974a) in which many ideas which later became ingredients of the HFA movement, were already documented.

A participative approach, working together in partnership, and appreciating the patient/client perspective e.g. in the nursing process, by validating the decisions made (WHO, 1987), have been important principles in nursing practice. Even more basic than conceptual and practical similarities in relation to man, health, and nursing action, may be the ethical basis which nursing shares with the HFA philosophy. The values of integrity, health and self-determination are found in both the HFA movement and in the historical roots of nursing.

1.7. Conceptual framework for the study

The Nursing Programme had two interrelated components: the overall organization of the project and the purely nursing component in clinical areas and in the schools. These required different theoretical perspectives for the analysis. The nursing framework is presented first and the organizational theory will follow.

1.7.1. Conceptual framework: metaparadigm concepts of nursing

In the theoretical literature on nursing, four concepts can be identified as representing the principal elements of the discipline of nursing. These concepts are 'man', 'environment', 'health' and 'nursing action' (Bush, 1979; Chinn & Jacobs, 1987; Fitzpatrick & Whall, 1983; Meleis, 1985; Torres, 1986). This 'metaparadigm is ...the most global perspective of a discipline' (Fawcett, 1984, p 5). Therefore, it is a suitable guide for the analysis of the final reports of various nursing projects. Chinn and Jacobs (1987) have pointed out that the recipient of nursing care may be an individual or a group of individuals, for example a family or a community, whereas the analysis by Stevens (1984) also includes the relationship between the basic concepts into the framework. Stevens discusses 'the patient', 'health' and 'nursing acts', but also the relationships of nursing acts to the patient and health, and the relationship of the patient to health. Flaskerud and Halloran have stated in their often quoted article: 'there is a consensus among nurses on the importance of these concepts' (Flaskerud & Halloran, 1980, p 3). The person and the needs of the person for nursing, health and deviations from health, were essential elements in the conceptual framework of the Multinational Nursing Study (WHO, 1987), which also characterizes the similar conceptual orientation of the wider European nursing community.

In this section, the purpose is to highlight conceptualizations of various authors to serve as a point of reference for the analysis of the final reports of the Nursing Programme. Due to its complementary nature, nursing is often intimately related to very personal matters or very personal situations in people's lives. This factor together with the health-illness-death issues makes the value system an essential

part of nursing. Because it is assumed that ethical principles are mainly drawn from the conceptualization of 'man', the ethical foundation of nursing is discussed in this connection.

Man According to nurse theorists, man is an energy field (Rogers, 1980); a behavioural system (Johnson, 1980); a personal system in interaction with its environment (King, 1981); or 'a unity that can be viewed as functioning biologically, symbolically and socially' (Orem, 1985, p 175). As an example, Roy's conceptualization of man is discussed at some length.

In the Roy Adaptation Model for Nursing (Andrews & Roy, 1986), the person is described as a holistic adaptive system and the person is nursed as an individual or a member of a group or the whole society. The recipient of nursing care can be well or ill. Man is conceptualized on the basis of the systems theory. Thus man is composed of parts which function coherently and therefore form an interrelated whole. This system, man, receives the input which is composed of the following two elements. Firstly, stimuli are coming to a human system both from the internal and external environment. The second element of the input is termed adaptation level which is shaped by focal stimuli (i.e. immediate concern), contextual stimuli (i.e. other recognizable stimuli) and residual stimuli (i.e. stimuli so far unvalidated).

The control mechanisms which are essential for any system to process inputs to outputs, are called coping mechanisms; these can be innate (genetic) or acquired (learned) coping mechanisms. Coping mechanisms are also called regulator (i.e. automatic) subsystems or cognator subsystems (i.e. cognitive and emotive). Assisted by these mechanisms, a person is reacting to his or her environment. As a reaction to a stimulus, a system will respond. A response can be seen as the behaviour of a person; in his or her behaviour the operations of coping mechanisms are manifested. 'The person's response is thus a function of the input stimuli and his or her adaptation level' (Andrews & Roy, 1986, p 21). Adaptive and ineffective responses represent the output and feedback of the human system. Ineffective response is a sign of an existing problem and effective response manifests adaptive behaviour. Adaptive modes or ways of coping, according to

Roy, are physiological mode, self-concept mode, role function mode and interdependence mode. The behaviour of patients takes place within these modes. To Roy, the person is 'an adaptive system with regulator and cognator mechanisms that act through the four adaptive modes to produce adaptive responses to the changing world within and around' (Andrews & Roy, 1986, p 7).

Integrity of a person is the origin of ethical principles in nursing. It is the essence of nursing to serve people and to work for their good in the health field. 'Nursing is rooted in the needs of humanity, founded on the ideal of service' (Lanara, 1981, p 40). Nurses are intimately related to very personal matters of their patients and clients. Due to the fact that matters of life and death/health and illness have particular significance to people, awareness of ethical implications of decisions made in nursing, becomes important. This fact puts nurses in a position where they become involved in matters which have ethical dimensions. This may happen when nurses make judgments, choose between alternatives, or decide about the extent of their involvement in the health of individuals, families, and communities.

Multiple obligations characterize the ethical position of nurses. The primary obligation to patients and clients is understood but at the same time it is evident that there are obligations to physicians, employers, colleagues and society at large. In addition to the multiple obligations, the institutional constraints have created a situation where exhibiting ethical qualities is not easy for nurses (Davis & Aroskar, 1983; Yarling & McElmurry, 1986). This is in turn related to the overall position of nursing in the health service system. Nursing does not have the autonomy to implement its ethical decisions. Therefore, it is pertinent to consider ethical dilemmas - not only as a concern of an individual practitioner - but also as they relate to institutional situations and to policy-making (Davis & Aroskar, 1983).

The ethical foundation of nursing requires the inclusion of ethical aspects in all decision-making processes (Schröck, 1980). There is also a very complicated field of moral reasoning which includes those special events in human life or special practices of health and nursing care which have emerged mainly from the modern

society and technological advancements. A reference is here made to ethical dilemmas which are encountered in regard to abortion, euthanasia, death and dying, mental retardation, organ transplantation, distribution of scarce resources and informed consent. The 'Health for All' ideology with its basic thrust of equity makes ethical reasoning even more a part of the everyday practice of nursing than it has been in the past. 'Health for All' may even be regarded as an ethical movement.

In this study, the process of identifying values and principles underpinning nursing and development of standards and criteria is perceived to belong to the realm of nursing ethics. This process of values clarification is also a part of any quality assurance programme but here it is discussed from an ethical viewpoint. A value is perceived to be 'an affective disposition towards a person, object, or idea' (Steele & Harmon, 1983, p 1), and values clarification is termed as a process whereby one will identify what finally is meaningful to a human being. A Finnish point of reference is a widely used nursing textbook (Veteläsuo, 1977) which, in regard to a patient, notes the respect for human dignity and human rights, and states the following principles of care: individuality, independence of a patient, security, health-centredness and continuity of care.

In summary, conceptualization of man as a holistic adaptive system was outlined. The integrity of man was seen to be the major source of ethical principles in nursing. In everyday decision-making ethical dimensions are involved, because matters of life and death are faced. Attention was drawn to the fact that exhibiting ethical qualities is not easy for nurses, mainly due to lack of autonomy. Identifying values, stating principles along with the standards and criteria, are a part of ethical nursing practice.

Environment Torres (1986) has presented Nightingale as the only environmental theorist. Indeed, to Nightingale (1980), the essence of nursing was to provide people, sick or well, at home or in the hospital, an environment conducive to health and recovery. Nightingale had observed that 'bad sanitary, bad architectural, and bad administrative arrangements often make it impossible to nurse' (1980, p 2) and she contended that badly constructed houses damage the

health of people. Nursing action was almost exclusively focussed on the indirect care, in other words, on interventions towards the environment. Nightingale identified several environmental factors which should be the constant concern of nurses. Among them were fresh air for a patient to breathe and for maintenance of the physical environment (e.g. patients' beds), but at the same time preserving warmth, pure water and efficient drainage and general cleanliness of the immediate environment of a person. A quiet environment where unnecessary noise has been controlled, was a concern of nursing, as was light and lighting conditions. Nightingale expressed her belief in light by stating that 'the sun is not only a painter but a sculptor' (1980, p 69) meaning that both the mind and the body benefit from light. Nightingale made reference to the aesthetic aspects of the environment arguing that 'variety of form and brilliancy of color in the objects presented to patients are actual means of recovery' (1980, p 46).

Indeed, Nightingale is a paradigm case of a theorist focussing on the environment. In her writing, Nightingale described in a revealing manner those environmental conditions which she wanted to be improved and the conditions she wanted to be appreciated by using aesthetic language. Obviously, Nightingale's times are reflected in her 'theory', but on the other hand, the 'essential points' in the human environment, though slightly altered, are a constant concern of nursing and of health service system generally.

More than a hundred years later, Mitchell (1973) began writing about the environment by noting the importance of air and water and of adequate housing. However, these and other topics were dealt with by referring to the existing environmental hazards from their negative sides; concerns of the modern world are air pollution, water pollution, and lack of adequate housing. There are other concerns as well, such as use of pesticides, overcrowding of people, inadequacies in food supplies and lack of privacy. These very broad environmental issues belong to the domain of nursing, for example, nursing includes health education which should help people to become aware of environmental hazards and of possible preventive measures. Thus, environment understood very broadly, is included in the 'environment' as a nursing concept (Mitchell, 1973).

However, Mitchell (1973) has limited her scope of discussion to the immediate environment of a patient/client at home, outpatient department and institution. Mitchell has chosen to discuss the following three aspects of the immediate environment: safety, infection control and the impact of the environment on health. Environmental safety takes the form of accident prevention in nursing. From this safety perspective, almost everything in the environment of a patient/client both at home and in the institution - under certain unfavourable conditions - is a subject of concern. The following are examples of matters which are included in the concept of 'environment': lighting of the environment, especially in the night time, all items necessary and used for living and functioning, such as furniture, especially beds and chairs, electric devices and hot items, constructions of the environment causing falling, substances and items which become harmful if not used for the right purpose, such as medicines, cleaning fluids, or very small items in reach of a small child. These matters in the environment become an issue to the person using the environment due to age (e.g. an infant or the elderly), sensory deficits (e.g. tactile, visual and auditory organs), impaired physical health, disorientation or necessary use of ambulatory devices.

A function within the nursing domain, particularly in institutional settings, is to protect patients from infections. There are several reasons why patients are at risk of becoming infected; the reasons may be certain medical procedures, diminished resistance of patients, and in the ward situation the mere proximity of others become risk factors. Because harmful microbes reside invisible in the environment, absolute and strict procedures and ways of organizing work and epidemiological orientation are essential parts of nursing action.

Included in the third environmental category - the impact of the environment on health and illness - is overloading sensory stimulation and sensory deprivation. The institutional environment, or other types of isolation, may create a situation where lack of stimulation leads to sensory deprivation, and that in turn, to disorientation. The opposite situation, where the stimulating affect of light, noise, and activity are excessive, sensory overload is the result. Thus these types of environmental effects are a concern of nurses.

Rogers' (1976; 1980) conceptualization of the environment focuses on one primary feature: environment is an energy field which is electrical in nature and where energy indicates the dynamic nature of the field. Essential in this theoretical formulation is, that also 'man' is perceived as an energy field. Man - environment fields have fluctuating boundaries. There is a constant exchange of matter and energy between these two fields. This exchange results in repatterning both in man and in the environment. Both these fields are unique, and unitary man and the environment are integral with one other. The environment includes everything which is outside the human field. The environment as an energy field is infinite, open and its wave pattern is 'always novel, always emerging, always more diverse' (Rogers, 1980, p 331). Complexity and heterogeneity in increasing order characterize the environment.

In summary, three conceptualizations of the environment were presented. Nightingale noted several essential environmental elements such as air, water, warmth, light, quiet, and cleanliness. By attending to environmental factors, the living conditions of people and the state of a patient can be improved. Mitchell dealt with many similar factors and concentrated on the immediate environment of a patient/client. The physical and mental safety of a person in the everyday or institutional environment was discussed. Rogers' conception of the environment as an energy field provided a dynamic and abstract idea of this metaparadigm concept.

Health According to Orem (1985), included in the concept of health are those mental qualities which characterize human beings and differentiate them from the rest of creatures. Similarly, the relationship of those mental qualities with the physiological, interpersonal and social life, are ingredients of the idea of health. Therefore, the idea of health will change when the conception of human or biological qualities of a person change. The term health, thus, includes physical, psychological, interpersonal and social aspects of living. Within an individual those four aspects are inseparable. Indeed, to Orem, health implies integrity and soundness, as well as structural and functional wholeness. However, the term health is used also when reference is made to the parts of the whole, be they mental functioning, a physiological mechanism, or an extremity of the body. Furthermore, some structural and functional alterations - e.g. a fracture and

concomitant immobility - do not have any serious impact on the integrity and the person does not necessarily feel himself or herself as being unwell. There is a temporary absence of wholeness but the person is not sick. According to Orem (1985, p 174) 'any deviation from normal structure or functioning is properly referred to as an absence of health in the sense of wholeness or integrity'. Orem goes on to state that the kind of distress ill health and its consequences will cause, means human suffering. But according to Orem, distress may lead to better understanding of oneself and others.

Attending to health matters requires a solid knowledge base of the health professionals. But people generally also have ideas about health to the extent that they are able to recognize their own feelings of health and the health status of others. To Orem, ideally, health is the responsibility of society and its individual members.

Newman (1980; 1983) builds on an understanding that a synthesis of the concepts of illness and health is required and that synthesis can be brought about through the following dialectical process: the concept 'disease' and its opposite 'non-disease' will merge and generate a synthesis which is termed 'health'. The same is diagrammatically presented: Disease-Non-disease -> Health (Newman, 1980, p 56). The diagram indicates that illness and pathology are included in the concept of health. For example, a chronically ill person may not consider himself sick; disease is a part of his total being. Disease is considered to be a factor in the development of an individual. Likewise, hardly anybody in adulthood is without some impairment of health, but regardless of that remains a whole person. Disease to Newman is a reflection of the pattern which the man - environment interaction has taken. That pattern is a permanent entity in man and if becoming ill is the only manner in which the manifestation of the pattern can take place, it is regarded healthy.

To Newman, health is 'the process of living to be experienced as fully as possible' (Newman, 1983, p 173), and it is also 'the expansion of consciousness' (Newman, 1980, p 58). The life process and therefore health, is approached and understood by Newman through this key concept 'consciousness' and its

correlates 'movement', 'time' and 'space'. Movement, e.g. its tempo, is characteristic to a person, and such inner states as thoughts and emotions are reflected in movement. The action-rest cycle is typical to movement and a human being is expressing himself or herself through movements. It is through movement that man becomes aware of himself and his body. Human activities may require coordinated movement and movement is a precondition for social relationships as it enables a person to approach others. 'Movement is a reflection of consciousness' (Newman, 1980, p 60). Newman states that time is a function of movement. A high level of consciousness is found in a situation where subjective time of a person is greater than clock time. Time is compartmentalized and space is broadened on the basis of the increase in mobility of a person. With diminished mobility - which is encountered e.g. in old age - life space is restricted and time will increase. The increase in time could be seen as an opportunity to expand one's consciousness, thus time becomes a measure of consciousness.

'The rhythm and pattern which are reflected in movement are an indication of the internal organization of the person and his perception of the world' (Newman, 1980, p 63). Newman argues that movement is an effective vehicle of communication. The corollary to nursing of this theory is, that its goal is not preventing illness and helping people to recover from illness 'but to assist people to utilize the power that is within them as they evolve toward higher levels of consciousness' (Newman, 1980, p 67).

Tripp-Reimer (1984) has suggested a model of health which incorporates culturally specific and culturally universal aspects of health. The model is based on a health grid, where the horizontal axis represents the objective and culturally universal aspects termed disease and non-disease, and the vertical axis represents the subjective and culturally specific aspects of health named illness and wellness. The model provides four quadrants. The quadrant that is formed by wellness - non-disease parts of the continua, represents similar views of client and provider dyad and promotive and preventive tendencies. The illness - disease quadrant as well, represents mutually corresponding views: a person feels subjectively ill and scientifically oriented providers are able to diagnose a disease. The illness - non-disease quadrant is characterized by disagreement between provider and recipient of care; the former is not able to identify any disease but the latter exhibits

subjective feelings of illness. The wellness - disease quadrant also includes opposing views. A pathological state is identifiable but no sense of illness exists.

In summary, three conceptualizations of health were presented. According to Orem, health means integrity as well as structural and functional wholeness. Some alteration in the structure and function does not necessarily have serious impact on integrity. Distress in the form of ill health may be an asset for better understanding of oneself and others. To Orem, health is related to the essential qualities of a human being. In her conceptualization, Newman has made a synthesis of disease and non-disease and thus her concept of health includes illness and pathology. Health is equivalent to the process of living and high level of consciousness. In understanding health, consciousness is a key concept, as are its correlates movement, time and space. Tripp-Reimer has presented a health grid, which assists in analysing health as defined by scientifically prepared providers and as experienced by recipients with varied cultural backgrounds.

Nursing action Peplau (1988), in describing nursing as a function, noted that individuals (in communities) are helped to grow towards health which is physical, emotional and social well-being. This direction is expressed more specifically in regard to the 'forward movement of personality'. Peplau states that creative, constructive, productive, personal and community living form the direction of growth. There is one intermediate goal for nursing and that is that individuals learn problem-solving skills. In the nursing process, nurses are interpreting and meeting psychological needs of their patients. Nurses share with their patients the solution to the problem. In human life, however, problems recur and therefore learning skills for problem solving is essential. Towards this end, nursing is both a therapeutic and an educative process. Nursing is also a maturing force because it enables individuals to learn needed skills. According to Peplau, nursing functions co-operatively with other human processes and facilitates natural ongoing tendencies in human organisms. These processes and tendencies are biological and social in nature; they are psychobiological processes of self-repair and self-renewal. To facilitate these processes, certain conditions have to be created by nurses together with their co-workers. Finally, and most importantly, nursing is an interpersonal process creating interpersonal conditions for growth and health.

The phases of this interpersonal process are orientation, identification, exploitation and resolution.

For Levine (1973), nursing intervention is based on scientific knowledge and on acknowledging holistic responses of recipients of nursing. 'The nurse must learn to read the message' (Levine, 1973, p 13). This statement is characterizing the quality of assessment in nursing. In Levine's thinking, four conservation principles of nursing provide a structure through which various nursing activities can be understood. By conservation, a balance is sought between patient participation, safety and nursing interventions. The four conservation principles are: (1) conservation of energy (e.g. providing nutrition and rest); (2) conservation of structural integrity (e.g. needs arising from surgical operations); (3) conservation of personal integrity (e.g. maintaining identity and self-esteem of a person); and (4) conservation of social integrity (e.g. fostering social contacts during hospitalization). Levine has demonstrated the use of the four conservation principles in various illness episodes and in clinical practice of nursing.

According to King (1981, p 2) 'nursing is perceiving, thinking, relating, judging, and acting vis-à-vis the behavior of individuals who come to a nursing situation'. Information for a basis of decision-making has to be collected and that requires observation and measurement techniques. Nursing has many facets: helping people to maintain their health, giving care to sick people and enabling chronically ill to use their potential for daily living; and nurses work in partnership with others. These facets require a command of many skills and techniques which, according to King, are applied within a standard procedure, i.e. the nursing process. Essential in nursing is, on the one hand, obtaining information about the client to form the basis for decision-making and on the other hand, applying knowledge from natural and behavioural sciences and humanities in serving the people. Assessment, interview and communication skills, and teaching, guiding and counselling skills are needed. King, however, seems to emphasize observation of behaviour and physical measurements. Knowledge and understanding are used in evaluating those observations and measurements, which will elicit planning, implementing and finally evaluation. In the whole process the nurse - client interaction is essential. According to King, this interaction becomes a transaction when it has a purpose and when it leads to goal attainment. In nurse -

patient interaction mutual goal setting takes place, the means for reaching the goal are mutually explored and the behaviour of the client and the nurse is geared towards the goal.

In summary, three conceptualizations of nursing action were described. According to Peplau, nursing is a therapeutic, educative and maturing process, which fosters the natural ongoing tendencies in a human being. Through an interpersonal process, conditions for growth and health are created. Levine has based nursing interventions on four conservation principles. King has noted that nursing has many facets in providing care on a partnership basis and that these facets require a command of a wide variety of skills. To King, observation of behaviour and physical measurements are significant skills. Observation and measurement provide information for decision-making in nursing. The nursing process is a guiding framework and within it, nurse - client interaction is essential.

It has been noted in the introductory chapter, that one of the areas of interest in the European Programme was the nursing process. It was also noted that the Multinational Nursing Study was conducted in the context of the nursing process. The nursing process is perceived to be a vehicle through which theoretical constructs and ethical basis could be incorporated into practice. In this section, mention has been made that, for example, King has referred to the nursing process as a standard procedure. Yura and Walsh have observed that the four phases of the nursing process, those of assessing, planning, implementing and evaluating, 'have become second nature to nurses everywhere' (Yura & Walsh, 1988, p 24) and Flaskerud and Halloran (1980) have argued that this systematic process of nursing is generally accepted by the nursing community. Indeed, one of the essential strategies used in the practice of nursing, is the nursing process. Through the systematic process of nursing, nurses assess the health status of a person, plan the nursing care, implement the plan by offering nursing care and evaluate nursing and its outcomes (Bower, 1977; Little & Carnevali, 1976; George, 1985; Roper, 1977; WHO, 1977b).

1.7.2. Conceptual framework: the organizational metaphors

In the organizational analysis Salaman (1981, p.7) has stated that 'organizations are tools'. The organization with committees, workgroups and their procedures built for the Nursing Programme, was a tool for implementing the programme ideas, and for achieving the goals. The organization existed for a very broad and complicated task. For the purposes of the analysis the whole life cycle (Kimberly and Miles, 1981) of that organization was followed.

The development of a theoretical framework for this study was greatly influenced by Morgan's Images of Organization which deals with 'the art of reading and understanding organizations' (1986, p 12). It is the basic thrust of Morgan's work (that of the use of diverse metaphors as a method of organizational analysis) which has made it relevant for the present investigation. As a basis of the analysis is the understanding that organizations are 'complex, ambiguous, and paradoxical' (Morgan, 1986, p 17). On the one hand, metaphors are seen to have a profound impact on thinking and language; on the other hand, as analytical tools, one given metaphor will always elicit only a partial view of the phenomenon under study, and therefore application of several metaphors is required. Each metaphor gives a different perspective on an organization, and therefore new understanding. Four metaphors from Morgan's extensive list of metaphors have been selected. The metaphors employed to facilitate the analysis in this study are: (1) organizations as machines, (2) organizations as organisms, (3) organizations as brains, and (4) organizations as political systems (Morgan, 1986). Behind the metaphors, there is a vast body of organizational literature, the significant areas are presented in the following section.

Organizations as machines The prototype of an organization as a machine is the type of organization which is known as bureaucratic. The essential belief supporting the machine-like organization is, that organizations are rational in their operations. This rationality is brought about by means of planning, organizing and controlling. A mechanistic organization relies heavily on preset goals and objectives, on predetermined sets of activities for goal-attainment, and on hierarchical supervision. Like in a machine, parts of an organization are

replaceable, in other words, individuals as workers, without taking into account their personal qualities, can be replaced and therefore, the process of work can be continued without interruptions. That entails two matters. The process of work is divided into well defined separate tasks, and through task assignment, people are involved in that chain of task performance. Human aspects of an organization are not of much concern, or rather, they are non-existent. On the one hand, increased specialization in terms of tasks is required, and on the other hand, the scope of tasks is narrow and the individual lacks the control of performance. Organizational structure is based on the existence of a hierarchy, and so it is believed that command from the top of an organizational hierarchy will result in expected effect at the bottom of the hierarchy. Mechanical precision is brought about through hierarchical supervision which is exerted by goals and objectives, and by rules and regulations. A machine-like organization ensures regularity, reliability and efficiency, and this type of organization is superior in circumstances where a machine could perform the activities. A machine-like organization is a poor alternative if a questioning mind, independence or innovations are expected or if they are positive preconditions for functioning (Morgan, 1986).

Theoretical work by Taylor (1919) and Weber (1947) are examples of a machine-like organization which builds on the principle of rationality. Taylor's organizational image gave birth to a system, whereby earlier integrated units of work were scientifically fragmented into small entities, for the organization to reach maximum effectiveness and control. The person performing those fragmented and specialized tasks had lost the comprehensive understanding about his work. The role of the manager was important in this system; thinking and planning were defined as managerial functions and they were both separated from the actual performance of the work. The selection and training of the employees for scientifically planned and scheduled tasks, was another important managerial function.

Weber's analysis of bureaucratic administration underscores the rationality of that type of organization, which is characterized also by unity, calculability, precision, speed, unambiguity and continuity. Bureaucratic organization is brought about by several means. Bureaucratic organization is clearly hierarchical and its activities are ordered by written rules (knowledge of the files). A scope of competence and

functional specialization of work within the hierarchy are clearly defined. Bureaucratic organization claims to have legitimate authority and based on that, exercise of control. The authority to give commands is hierarchically distributed and bureaucratic administration can rely on precise obedience to commands given from above. This obedience may be based on custom, affectual ties, or material interests. Only a person with defined competence in the form of an expert training and technical knowledge can be appointed to become an official. A bureaucratic apparatus provides to its officials upward career mobility. Work is separated from private life and the obedience to authority is impersonal. Superiors in a hierarchy supervise the subordinates (Gerth & Mills, 1964; Weber, 1947).

Organizations as organisms The organic metaphor combines several separate conceptual orientations which have all drawn their images of organization from biology. Morgan has given the following parallel concepts: 'molecules, cells, complex organisms, species, and ecology' are, in a theoretical sense, comparable to 'individuals, groups, organizations, populations (species) of organizations, and their social ecology' (Morgan, 1986, p 40). The organic organization is concerned with the organizational needs and environmental relations. Identifying and satisfying the needs of an organization will also lead to the satisfaction of needs of people. In meeting their internal needs, the organizations have to reconcile the technical requirements with the human interests. As is the case with a biological system, survival is a concern of an organization as well. In satisfying its needs the organization is dependent on its environment, and is seeking supplies from its environment to build a resource niche for its functioning. A prerequisite for this organizational function is the constant observation of the environment. This environmental relationship may lead it to collaboration or competition. A factor, contributing to the organizational well-being is participative and democratic leadership (Morgan, 1986).

This idea of species of organizations which appears in the Morgan quotation, originates in population ecology (Aldrich, 1979) which operates from the perspective of natural selection and survival. Population ecology as an organizational theory is focussed on change (i.e. establishment, maintaining and development of organizations) and on the environment. Through its resources the environment regulates the organizational change and competition becomes a crucial

organizational activity. The kinds of resources which support organizations in growth and development are, for example, human activity, knowledge, influence, reputation and money. Any functional combination of resources in support of an organization will constitute a niche or 'viable mode of living' (Aldrich, 1979, p 30).

An organizational analysis may employ another biological image, that of life cycle and study etiological aspects of organizations (Kimberly, et al., 1981). Phases of life cycle may be called chapters in the biography of an organization. In an organizational life cycle, the analysis is focussed on birth and its context; on childhood, early development and organizational learning; on organizational structure, design of work and systems of control in normal life; on decline and death of an organization. In this theoretical construct, organizational environment is also observed.

Perceiving organizations as open systems with several subsystems is one facet of the organic metaphor. Contingency theory - which acknowledges both organizational needs and the notion of open systems - has concentrated on the relationship between the organization and its environment. According to this theory, different kinds of environments require different kinds of species of organizations and inside a given organization, due to the various sub-environments, internal differentiation is needed (Morgan, 1986). This metaphor sees organizations as living systems in their environments (Miller, 1978), and the life of an organization is like a process. Therefore, there can not be one superior form to design organizations.

Organizations as brains Organizations as brains provide a new perspective. Behind this metaphor is the challenging question: would it be possible to design an organization which has the potential of a brain to receive signals from the environment, to process them, and to initiate intelligent action? The essence of a brain-like organization is that, dispersed to all its parts is the faculty of being intelligent, creative and flexible. Information receiving and processing along with learning take place in all parts of an organization. Based on the capacities mentioned, a brain-like organization is able in changing conditions to evaluate its

functions and to reorient them. This is to say that the capacity to perform all the significant functions of an organization penetrate the whole establishment. Morgan (1986) has remarked that the brain metaphor has been applied in a more narrow sense as well, and in those cases a concept of a brain-like organ to do the 'thinking' for the rest of the organization has been instituted (Beer, 1972). However, that is not the challenging use of the metaphor.

Several theorists exemplify the view according to which organizations have some brain-like qualities. According to Simon's (1976) decision-making approach, the limited capacity for information processing of human beings also renders organizations incomplete in this function. Therefore, to compensate for the limits of human rationality, varied types of structures have been instituted in organizational life. In all organizations, information is processed in some way and organizational members get information for their decision-making through communication systems. Jobs, departments and their divisions, hierarchies and rules, in a given organization, have been created to make organizational life manageable. However, the routines and compartmentalization thus brought about, together with formalized structures for action, have a pervasive impact on the manner in which organizational members see and interpret their work. The result may be a lack of overview as regards one's work. Morgan has used the expression 'institutionalized brains' (1986, p 81) when discussing this kind of development in organizations. It is worth mentioning that programmes, such as the one evaluated in this study, are also seen as devices instituted to make the otherwise complex organizational life more manageable.

If the stable and rapidly-changing organizational environments are considered together with this information-processing capacity, the manner, in which mechanical and organic organizations design their information flow, can also be explored. In stable environments, activities may be strictly planned and organizational behaviour is controlled by procedures and rules. In turbulent environments, organizations use goal setting and targeting and in organic organizations information-processing and decision-making tend to take place more on an ad hoc basis. The developments in electronics which have changed and continue to change microprocessing techniques and computers and thus the flow of information and the means of communication will have a profound impact on

the manner in which work will be organized in the future. Morgan (1986, p 84) has even seen the possibility that organizations are 'becoming synonymous with their information systems'.

Cybernetics (Wiener, 1961; Ashby, 1964) is an example of the brain metaphor. Cybernetics provides the possibility of constructing machines and organizations which, based on the negative feedback from the environment, are able to regulate behaviour automatically. It is the detection of errors which will keep the organization on course. And from those basic cybernetic principles, two types of organizational learning have been developed. Single-loop learning involves three steps: the system (in this case an organization) is able to monitor changes in the environment, to compare the information so gained with the operating norms of the system and to take the appropriate action. In double-loop learning, one important step has been added, that of questioning the relevance of a given operating norm. It is the double-loop learning which constitutes that important organizational skill which has been called 'learning to learn'. There are constraints to these types of organizational designs, but there are factors which also represent impulses. Remaining open to the changes taking place in the environment, and retaining the sensitivity and imagination to question the assumptions underlying norm-like operations, are the fundamental prerequisites which will give to an organization the capacity of 'learning to learn'.

Holographic organizational design is probably the most far-reaching of the designs belonging to the 'brain metaphor'. The principle of holography is both simple and revolutionary; the whole is encoded into the smallest piece of it. When that principle is taken to the level of institutional arrangements, it means that capacities necessary for any given organization should exist in its parts, or as Morgan (1986, p 97) has suggested: 'get the whole into the parts'.

Organizations as political systems When introducing organizations as political systems, Morgan (1986) has noted that organizations are inherently political in the sense, that the varied interests of organizational members have to be reconciled to bring about order and to make an organization functional. But also on a much smaller scale, as a part of the everyday operations of an organization,

members attempt to promote various interests which are external to the official policy and therefore, are not discussed publicly and therefore remain invisible.

Interests, conflict, and power, are the key concepts in Morgan's analysis of organizational politics. By interests the reference is made to 'a complex set of predispositions embracing goals, values, desires, expectations and other orientations and inclinations that lead a person to act in one direction rather than another' (Morgan, 1986, p 149). Morgan has remarked that traditionally, conflict is perceived as something unfortunate, not belonging to the organizational life. Yet, he argues that because the disagreement between the interests is inevitable, conflicts will be present in organizations. Use of power is a vehicle through which those ever-present conflicts between interests are solved. Morgan oriented his analysis of power from the definition by Dahl (1957) who outlined power in the following manner: 'A has power over B to the extent that he can get B to do something that B would not otherwise do' (Dahl, 1957, pp 202-203). Morgan has identified several sources of power, from them, the following have been selected for this study: formal authority, control of scarce resources, control of decision processes and control of knowledge and information.

The metaphors will assist in reading and understanding organizations. Morgan has advised the organizational analyst firstly, to begin with the assumption that organizations are 'complex, ambiguous, and paradoxical'; and secondly, to adopt the view that organizations embody several images simultaneously; for instance, in a given organization it is possible to identify machine-like characteristics, open organic practices and modern information processing. There is also an interesting connection between the organizational analysis by Morgan and the programme evaluation research. Organizational analysis proceeds through the following two phases: it will begin with a diagnostic reading of an organization by using different metaphors to point out the key features; that phase will be followed by a critical evaluation of the importance of the different interpretations. In critical evaluation the analyst will be exploring competing explanations and will end up with some kind of comprehensive picture. This identification of the significance in the course of the analysis, is in principle the same procedure which is employed in the programme evaluation.

In summary, the four concepts 'man', 'environment', 'health' and 'nursing action' have been selected in this study to form a conceptual frame of reference within which the nursing content in the Nursing Programme has been described and analysed. For the organizational analysis of the Nursing Programme, four metaphors or images have been identified. These metaphors are: organization as a machine, organization as an organism, organization as a brain, and organization as political system.

2. Literature review

2.1. Introduction

The major part of the literature which provides the background for the theoretical and methodological analyses of this study is presented in this chapter. In the following section (2.2.), the scientific tradition in which this study is located is introduced. This epistemological discussion will also be employed as an evidence when the adequacy of the knowledge base for practice is later discussed as a part of the evaluation. In the next section (2.3.), the professional development of nursing is outlined in general terms. Professional development along with the epistemology of nursing and the metaparadigm concepts will form the point of reference for exploration of the Nursing Programme vis-à-vis the general developments in the profession and discipline of nursing. In the last section (2.4.), evaluation perspectives of the study are discussed. In the first sub-section, three approaches to service evaluation will be discussed. This was the strategy used in the evaluation of nursing services. In the second sub-section, programme evaluation will be introduced. This was the strategy used in the evaluation of the overall Nursing Programme. Literature reviewed covered the ten last years and important older sources were included.

In the following figure, the conceptual framework presented in the previous chapter (appears under theoretical perspectives) and the content of this second chapter are brought together and their role in the total evaluation of the Nursing Programme is shown.

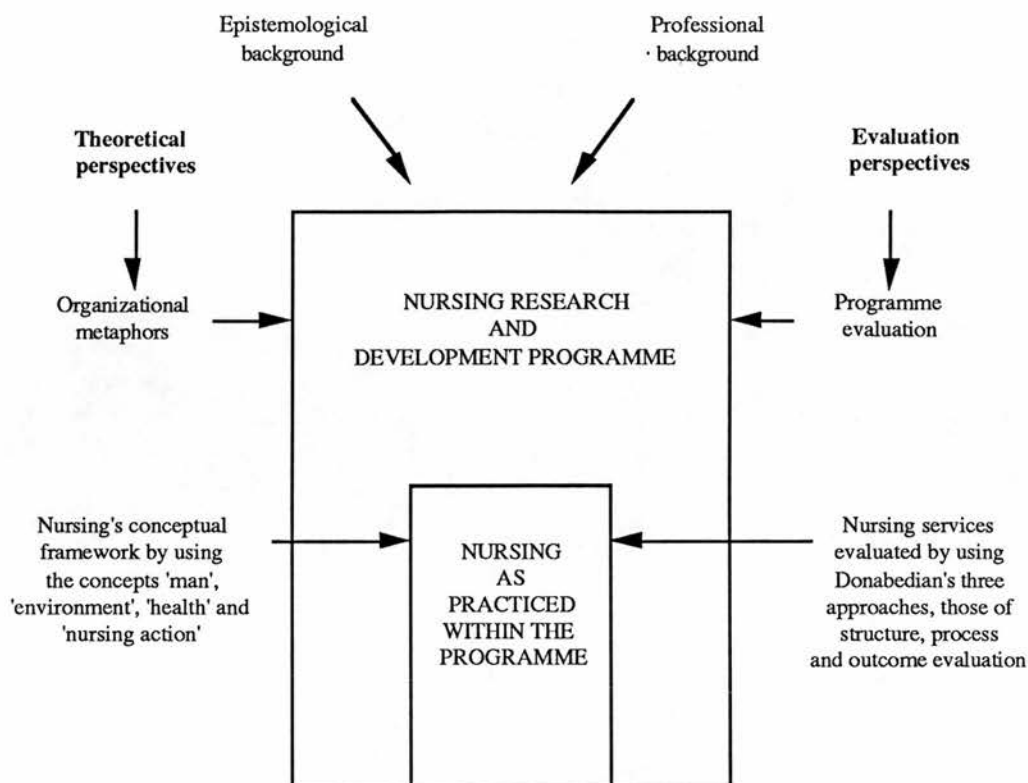


Figure 2.1. Conceptual and theoretical perspectives as they relate to the study

2.2. Epistemological perspective: the scientific tradition in which this study is located

2.2.1. Introduction

In pursuing scientific research, one becomes in principle a part of the social world which in itself as well as in its products is the focus of the philosophy of science. Epistemological and methodological assumptions have an impact on the investigation whether the assumptions are left implicit or made explicit. In the present study, it is an integral part of the research strategy to explicate how this particular investigation relates to the content of the philosophy of science and to the body of nursing knowledge. When explicating the position of the present study regarding epistemology, it has not been sufficient to deal with only the general issues in the philosophy of science. It was essential to raise questions which are specific to nursing as a discipline. Therefore, it is believed that the established forms of epistemology and

its applications to nursing should be analysed and discussed side by side, so that the conceptual structure comes from epistemology and the content from the discipline of nursing. Nursing as a discipline has not appeared as an 'instance' in general epistemological literature as have the social and biological sciences which have had impact on the development of the knowledge base of nursing. However, some philosophers have addressed epistemological issues focusing exclusively on nursing (Dickoff & James, 1968a; Dickoff, James & Wiedenbach, 1968; James & Dickoff, 1984).

The rationale underlying the epistemological analysis as a part of this research can be described with the following four points:

1. It is necessary to make clear what is seen to be the ultimate goal of science in society and, in principle, each research effort will be directed to that goal.
2. Understanding the inner nature of scientific practice leads to the area of general methodology which will suggest on what grounds research methods are justified.
3. Being aware of what constitutes knowledge at any given time has great significance. The selection of the research topic and the adoption of methodology are both dependent on the prevailing conception of knowledge and on the shifts in that conception.
4. The general preconditions for any science to progress and the nature of growth and development in knowledge, are also points needing clarification.¹

In nursing, epistemological discourse is a relatively recent matter as compared with natural and social sciences. Search for the nature of knowledge in nursing - which this discourse exemplified - has been a reflection of a more general debate in the philosophy of science (Allen, 1985; Baer, 1979; Silva, 1977). In major theoretical literature, specific epistemology of nursing has been the subject of work of Chinn and Jacobs (1987), and has been thoroughly discussed by Meleis (1985). Other nurse theorists have also dealt indirectly with epistemological matters when they have

¹Epistemological discourse can also be found in relation to programme evaluation and organizational research. Reference is made, for instance, to Burrell and Morgan (1979), Guba and Lincoln (1982b; 1985), House (1980), and Morgan and Smircich (1980). However, in this study, epistemological matters are discussed based on the main focus of the investigation, in other words, in terms of nursing.

suggested how nursing might be conceptualized or how nursing knowledge might be generated.

Kuhn (1970), a physicist and philosopher of science, proposed a revolutionary theory to explain the scientific progress. His analysis has played a key role in the debate within scientific communities, and nurse scholars have also been part of that debate. Hardy (1978) proposed that the developments in the discipline of nursing could be illuminated by Kuhn's notions of the paradigmatic changes and the revolutionary nature of scientific development; whereas, Meleis (1985) identified the evolutionary nature of scientific development as being more characteristic of nursing and her major argument against a revolutionary interpretation was the human and complex nature of nursing. Indeed, the practice of nursing is formed by a complex series of actions, which are usually intimately related with human beings. Therefore, it is understandable that scientific progress in nursing has not been characterized by sudden and complete changes in the paradigm(s), which would have implied sudden and complete changes in the practice of nursing as well. In practical terms, the consequence of Meleis' assertion would be that nursing as a totality has been practised according to the accepted intellectual and ethical norms in the society, where any remarkable deviation from the norms has been prevented, and that it has been through evolution that change has taken place. It can be added that justification of only one prevailing paradigm at anyone time, would have been difficult if not impossible.

Viewed as an historical and international process, the development of the discipline of nursing has embodied another feature which explains why progress through scientific revolution may not be a proper descriptor. That feature can be described by making a distinction between the institutional history i.e. external factors, and the cognitive history of a science (Niiniluoto, 1983). It has been the institutional history which has dominated the scientific progress. Reference is here made to such factors as making the nature of the discipline of nursing understood in academia, scarcity of nurse-scientists (mainly an educational issue but also related to the lack of tradition) and lack of material resources. In nursing, much of the energy has gone into the establishment of the prerequisites for the cognitive development and in many European countries the creation of the preconditions for cognitive development is a recent matter. The nature of nursing, stressed by Meleis, along with the historical picture makes nursing very different if compared with natural and social sciences and their long scientific

traditions. Therefore, Meleis' suggestion that the development of nursing knowledge has been a convoluted process seems to characterize the progress: 'The discipline of nursing evolved through peaks, valleys, detours, circular paths, retracing of steps, and series of crises as well as an evolutionary process' (Meleis, 1985, p 63).

The conceptualization of nursing, identification of nursing knowledge and knowledge utilization were key areas in the Nursing Research and Development Programme in Finland. Knowledge is an important entity by which nursing as a discipline and profession can be understood, explained and developed. Three questions related to this discussion will be addressed:

How is the scientific nature of nursing understood?

What is nursing knowledge or what constitutes knowledge?

How is nursing knowledge acquired?

2.2.2. The nature of nursing as a science

In order to understand the growth of knowledge, both the growth of scientific knowledge and nonscientific knowledge should be considered (Putnam, 1985) and this applies as much to nursing as to any other discipline. It is argued that the goal of scientific efforts in nursing has not only been to generate information about reality in a systematic manner, which would have meant the full adoption of the views of scientific realism (Niiniluoto, 1983), but that efforts in nursing have also been directed to or linked with practical applications as well. However, it seems possible to state that there has been basic and applied research in nursing; the former has been exemplified by theory development and the latter by studies of the impact of nursing interventions. Based on the assumptions in basic sciences, some nurse scholars have stressed the significance that nursing research has also produced empirically supported laws in the same sense as the sciences (Hardy, 1974). If the position of pragmatism is taken - as opposed to realism - a lawlike status would be given to particular empirical generalizations by nurses themselves and in that case those laws would not be independent of reasoning in the discipline and profession. This active contribution by nursing in identifying knowledge may make it understandable that it is not reasonable to exclude that kind of investigative outcomes outside the domain of nursing, though

the phenomenological stance seems currently to have an emerging intellectual role in the development of nursing knowledge.

The purpose of science has been seen to be, the generation of knowledge to be used for problem-solving (Munhall & Oiler, 1986) or as Laudan has stated: 'science is essentially a problem-solving activity' (Laudan, 1977, p 11). Nursing as a science - like ecology or social policy which Niiniluoto (1983), a Finnish philosopher, has used as examples - is producing recommendations for action. Barnard has expressed this same notion: '...how the science of nursing holds itself accountable to the practice of nursing, and, in turn, how the practice of nursing meets its accountability to the society which it serves' (Barnard, 1982, p 2). A theory for a practice discipline such as nursing can be normative as, for example, Grypdonck (1980) has argued. The major scientific interest of nursing as a practice discipline has focussed on the wholeness and uniqueness of every individual and his or her experiences as they relate to health and illness. In other words, singular cases and occasions are typically the focus of scientific interest, where knowledge is built through explaining and understanding individuals rather than through attempts to seek generalisable solutions.

2.2.3. What constitutes knowledge for nursing and in nursing?

In the philosophy of science, discourse about the ways science is progressing generally or about the phases in knowledge development implicitly, seems to entail historical perspective. General epistemological discussion portrays the growth of human knowledge through centuries (Kuhn, 1970; Meleis, 1985). Wartofsky, a philosopher, has proposed 'an historical epistemology which starts from the premises that the acquisition of knowledge is a fundamental mode of human action; that it is therefore inseparable from other forms of human practice; and that it is also inseparable from the historicity of these other modes, that is, from their historical change and development' (Wartofsky, 1987, p 358). The historical perspective is also suitable when the nature of nursing knowledge is discussed. The phases through which knowledge for nursing and in nursing has evolved since the 1850s is broadly outlined in this section. The purpose is to show the pattern of knowledge development as well as its interrelatedness with the general development in the profession of nursing.



The intellectual history of nursing began with Nightingale whose writings identified health and environment to be important foci (Nightingale, 1952, originally published in 1859). Meleis (1985, p 65) viewed this early conceptualization to be so clear-cut that she has coined the expression 'Nightingale's concept of nursing'. According to Baly (1987), already at the Nightingale School, the medical model was adopted due to the fact that nurses in training had to be prepared to perform tasks which earlier had been done by physicians in acute hospitals. Miss Nightingale herself was ambivalent in the face of that kind of development. The significance of that development lies in the fact that other countries tried to learn about the advancements in nurse education in England, including countries such as Finland (Pohjala, 1965; Tuulio, 1948), and the USA (Barritt, 1973).

The time from Nightingale to Peplau (i.e. from 1859 to 1952) did not generate any genuine nursing theories (Meleis, 1985; Torres, 1986). The development taking place during that time may be best described by dealing with the institutional history of the nursing science. Thibodeau (1983) considered the gradual conceptualizations of the essence of nursing in the years between Nightingale and Peplau to have contributed to the development of theories. Meyer and Heidgerken have indicated the emerging trend of nursing research already during the period from 1860 to the First World War. The methodology employed by those early investigators was 'the age-old technics of recording, reporting and armchair thinking' (Meyer & Heidgerken, 1962, p 30). In the period considered in this paragraph, academic education for nursing was instituted. One of the first initiatives for getting the needs of nurses for higher education recognized in academia came from the Teachers College, Columbia University in 1899. At the University of Minnesota basic nursing education was incorporated into the academic system in 1910, and the Yale University School of Nursing (1923), the Western Reserve University School of Nursing (1923) and the Vanderbilt University School of Nursing (1925) were also pioneers of that era (Abdellah & Levine, 1986; Fitzpatrick, 1983; Meleis, 1985; Polit & Hungler, 1987). During those same decades the groundwork for nursing research was laid down. Nursing matters became the focus of investigation and in the beginning, social scientists were appointed as investigators. The organized efforts for research in nursing on a continuing basis dates back to the year 1949 and the first book on nursing research methods was published in 1962 (Meyer & Heidgerken, 1962). One of the hallmarks in knowledge development

at the end of the period outlined here was the establishment of the journal Nursing Research in 1952¹.

Using Johnson, who according to Meleis had a key role in conceptualizing nursing as an exemplar of the period, the next phase of the development is described. According to Johnson (1959a) changes in society at large and in people's health practices, had resulted in changes in health services. Proliferation of knowledge in natural sciences, medicine and social sciences, had given rise to new applications in health care. In that kind of situation, the nature of nursing and the identity of professional nurses were placed under scrutiny. Johnson advocated the need to identify the specific responsibilities of nursing (1961a), and suggested that a clear conceptualization of nursing was required (1961b). Johnson began to give shape to what she called the science of nursing (1959a; 1959b), and she was involved in the first theory classes taught in the USA. That took place at the University of California, Los Angeles in the late 1960s (Meleis, 1985). Johnson (1964) argued that a weak knowledge base has been one reason for the tendency to delegate parts of nursing to auxiliary personnel, as well as for the tendency in nursing to assume medical and/or administrative practices. Johnson's explorations finally produced the behavioural system model for nursing which is outlined briefly in the next two paragraphs.

According to Johnson the basis of the behavioural system model was philosophical and that basis was the role of nursing in man's well-being (Johnson, 1980, first published in 1974). The role of nursing was to promote 'efficient and effective behavioral functioning' (Johnson, 1980, p 207). The development of the model has been supported by advancements in behavioural and biological research. In Johnson's model, the person was viewed as a behavioural system which consisted of the following eight sub-systems: (1) achievement sub-system, (2) affiliative sub-system, (3) aggressive-protective sub-system, (4) dependence sub-system, (5) eliminative sub-system, (6) ingestive sub-system, (7) restorative subsystem and (8) sexual sub-system. Originally, the model included seven sub-systems, and nursing scholars who

¹ For comparison, similar milestones from Finland can be mentioned: the first proposal for academic education for nurses was made in 1920; the first scientifically oriented publication, the Yearbook of Nursing, was established in 1958; the Nursing Research Institute, a purpose of which was to promote health services by investigating nursing, was established in 1966; and the first degree programme for nurses and other health professionals enrolled its first students in 1979.

have implemented the model have added the restorative sub-system into the model (Auger, 1976).

Each of the sub-systems had a structure which was formed by goal, action, set and choice. The goal as a structural concept referred to the goal of a given sub-system as an integral part of the behavioural system. Action was the only structural element which could be directly observed and it was fulfilling the inner purpose of a given sub-system. By the Johnson's concept, choice referred to the person's behavioural repertoire which may be limited to few behavioural responses or to include a wide range of them. The person's tendency to behave in a patterned manner was called set. Each sub-system had to be protected, nurtured and stimulated. Those three elements were called functional requirements and they served the sub-systems in fulfilling their part in the whole system. The person as a behavioural system was interacting with his environment which was seen to be composed both of the internal environment of a person and his or her external environment (Johnson, 1980).

In addition to the general outline given in the preceding paragraphs, two other themes can be identified in Johnson's thinking which have been fundamental to the understanding of what constituted knowledge in nursing. Firstly, Johnson has explored the role of biological and social sciences in the knowledge base of nursing and has identified some areas of relevance to nurses and other health workers, so called shared knowledge (1959a; 1959b). Later, Johnson (1968) made a distinction between borrowed and unique knowledge. Borrowed theory was developed by other disciplines, but it was necessary for nursing practice, whereas, nursing theory was built on the understanding of the unique nature of nursing. Secondly, discussion about the knowledge base of nursing was linked with the overall professional growth in which advances in education were crucial (Johnson, 1961a; 1964; 1974).

Later, other nurse theorists have continued discourse of the same issues. Fitzpatrick (1983) has pointed out that around the 1960s, identification of the content of professional nursing was related to developments in academic nursing education. Kim has called theories emerging from borrowed knowledge 'theories in nursing'; whereas 'theories of nursing were those developed to explain and predict "nursing" as a class of phenomena proper' (Kim, 1983, p 2). Walker and Avant made a distinction

between borrowed theory and theory derivation. In the former, 'the theory is moved unchanged from one discipline to another' (Walker & Avant, 1988, p 184), whereas the latter included modification of some content or structure of a given theory in such a manner that new insights are obtained. McFarlane believed that, through transmission, the pure science 'becomes part of a unique body of knowledge belonging to the practice discipline' (McFarlane, 1976b, p 446).

Theory development was promoted through collective efforts (e.g. Symposium on Theory Development in Nursing, 1968; Conference on the Nature of Science in Nursing, 1969).¹ This indicated the belief that by developing theories, nursing knowledge could be advanced. The following definition was suggested for a theory: 'theory is a conceptual system or framework invented to some purpose; and as the purpose varies so too must vary the structure and complexity of the system' (Dickoff & James, 1968a, p 198). Dickoff and James believed that a practice discipline such as nursing had a positive precondition for theorizing through its intimate relationship with empirical reality. This empirical reality, i.e. the practice of nursing, was identified to be the origin of theories which were supposed to return to practice when refined by research. Furthermore, it was this practice linkage or professional purpose which seemed to require, not only conceptualization on a descriptive level, but higher level theories as well.

There has been a flood of nursing theories or models since the 1950s (Peplau, 1988, theory first published in 1952; Harmer & Henderson, 1955; Abdellah et al., 1960; Travelbee, 1964, Roy, 1970; King, 1971; Paterson & Zderad, 1988, first published in 1976; Orem, 1985, theory originates from 1958, first published in 1971; Roper, Logan & Tierney, 1985, model first published in 1980; Watson, 1985). The conceptual roots of theories can be said to be found both in the sciences other than nursing and in the nursing experience of the theorists themselves. It is not exceptional that theory construction has been supported by research and/or validation in practice. Conceptualizations of nursing generated by Henderson and Abdellah have been the

¹In the literature, the words 'theory' and 'model' are often used interchangeably. Fawcett (1984) is one of the nurse authors who has made a clear distinction between models and theories. According to Fawcett, conceptual models are global ideas about the disciplinary subject matter whereas 'theories address phenomena with much greater specificity' (p 5). In this study, these concepts have been used as the sources have suggested. In any case both of the words seemed to refer to the significance of conceptualization and analytical clarity.

ingredients of nursing education in Finland and the essential material has been available in Finnish. Henderson's conceptualization of nursing has special significance because the International Council of Nurses adopted and published her professional and theoretical views (Henderson, 1969; ICN, 1961). Furthermore, Henderson's conceptualization, was adopted for the WHO Medium-Term Programme in Nursing/Midwifery. A recent survey made in Europe showed that both internationally known theories and some national conceptualizations were employed in nursing on various levels of specificity (Nursing/Midwifery Unit, 1987). It can be argued, based on the survey, that the nursing community has responded positively to the conceptual development.

This prevailing picture in theoretical development has had its opponents. By using pure logical reasoning, Beckstrand (1978a; 1978b) has come to the conclusion that practice theory is unnecessary for nursing. Making changes, controlling events and moral conduct are all based on pure science or ethics. What has been believed to be the content of practice theory has been reducible to the theories of science or ethics. Later, Beckstrand's position was that theory development suggested by Dickoff, James and Wiedenbach 'is roughly equivalent to a plan of action' (Beckstrand, 1980, p 69); whereas according to the same author, knowledge for nursing can be generated by employing the methods of science, ethics and philosophy.

More recently Melia and Fawcett (1986) presented a different type of criticism about theorizing in nursing. According to these authors, prevalent nursing theories - notably the mainstream of theories of the 1950s - 1970s, though the names of the theorists were not mentioned - are 'moral injunctions', all embracing and generated more or less through armchair theorizing; whereas, theories produced through an inductive approach result in explanatory accounts of reasonable scope. The kind of theory suggested by Melia and Fawcett for the discipline of nursing, was a formal theory linked with a particular conceptual entity and fed by substantive, empirically grounded theories. Melia's and Fawcett's critique seems to be directed towards methodological inadequacy in theory development rather than the need for theories.

However, the literature seems to suggest that theorizing has not been quite as one-sided as Melia and Fawcett suggested and that the need for empirically grounded

theories has also been recognized. Wald and Leonard (1964) have referred to the fact that theoretical development in nursing was first dependent on medicine and later on education, biological sciences and social sciences and these authors contended that nurses should use 'their own powers of observation and their own intellect' (Wald & Leonard, 1964, p 312). In a discussion of knowledge development, Wald and Leonard proposed the empirical study of nursing experience, first, to identify the concepts, and then, to generate nursing practice theory. According to these authors, this type of theory had to be a causal theory and include prescriptions for professional practice. In 1967 Quint advocated fieldwork and collection of empirical, qualitative data from which substantive theory could be derived. Already two decades ago Leininger (1969) suggested the ethnoscience approach and the 'dare-to-examine' attitude when the nature of science in nursing was discussed.

During the 1970s and the 1980s, discussion and conceptual development related to the alternatives has continued. Paterson (1971) described an human method of nursology (i.e. study of nursing for development of nursing theory) which combined the experiential knowledge of the nurse-investigator and philosophical ideas. To Schlotfeldt (1971), who relied on empiricism and inductive thinking, the most promising vehicle in developing scientific theories for nursing practice was empirical research, where repeated and systematic observations of phenomena essential in nursing became the ingredients of theory development. By uncovering weaknesses in explanations and facilitating the production of theoretical formulations, empirical research will advance the practice of nursing. Käppeli (1984) explored self-care needs, nursing needs and nursing assistance among the elderly hospitalized patients by using a grounded theory approach. Gottlieb and Rowat (1987) described a practice-derived model which was developed within the paradigm person, health, environment and nursing. This model which is called the McGill model, was built around the concepts of health, family, collaboration and learning.

These are just a few examples of the alternative approaches which seem to suggest that methodologically, efforts in theory development show considerable variety. Common to all, however, appears to have been a constant concern to generate knowledge which would be relevant and useful to clinical nursing practice.

The assumptions underlying nursing theories have been a point of clarification in theoretical debate. Assumptions about human nature are embodied in nursing theories and models and it was from this perspective that some nursing scholars discussed various conceptualizations. Fawcett (1984), in the analysis of nursing models, has noted that, logically, nursing models represent competing world views and that there are pervasive differences in the major thrusts between the models, namely between development and growth or interaction or systems notion as a major thrust. Similarly, McFarlane (1986a) questioned whether a model could be adequate for nursing if it was built exclusively on physiological or social origins. Taken literally, these assertions would mean that nurses have to encounter incompatible paradigms. On the whole, however, it seems possible to argue that nursing models and theories have not been perceived and received as representing competing paradigms which would be different in an irreconcilable manner. Rather, they have been perceived as conceptual entities providing rich alternatives which facilitate deeper understanding and therefore professional nursing practice. Theoretical pluralism seems to circumvent the ontological issues and give importance to various conceptualizations providing rich alternatives. However, theoretical pluralism is considered necessary for the knowledge development in nursing (Botha, 1989; Fawcett, 1984; James & Dickoff, 1984; McFarlane, 1986b; Meleis, 1985).

The profession of nursing has used a large share of its resources in knowledge building and in establishing scientific credibility. That work has included opening universities to nursing, establishing research training schemes and establishing research programmes. It may be argued that the profession has not been so passionate in opening novel avenues in nursing practice. Obviously, the ultimate goal in the development, referred to in the preceding paragraphs, has been the advancement of the practice of nursing and through that the common good of people. Yet, it is the developmental pattern followed which has inhibited the achievement of the most favourable outcomes for all parties involved (i.e. patients and clients, practitioners, educators, investigators and administrators). Schön (1983) has dealt with an issue comparable with the developments discussed here. Schön's framework was the general analysis of professions and he noted the importance of the institutional connections between research, education and practice. In nursing on the whole, institutional connections between the three elements have been weak. They have distanced knowledge development from practice; educational arrangements have not distributed knowledge generated by scientific work evenly but by creating hierarchies;

those who offer nursing have had least opportunities for acquiring that knowledge. Furthermore, in his epistemology of practice Schön has discussed knowing-in-action and reflecting-in-action and suggested that the latter, when realized, would make the practitioner a researcher as well.

Nursing may now be on the threshold of a different kind of development. Carper can be considered to be a good example of the new orientation. Carper (1975; 1978) has introduced four fundamental patterns of 'knowing' in nursing. Those patterns are: (1) empirics which is synonymous with the science of nursing, (2) aesthetics by which the art of nursing is called, (3) a personal knowledge in nursing and (4) ethics, in other words, moral knowledge in nursing. Because by this suggestion, equal status has been given to all patterns of knowing in nursing, scientific and nonscientific knowledge are both appreciated. This is in accordance with Laudan's view that 'there is no fundamental difference in kind between scientific and other forms of intellectual inquiry. All seek to make sense of the world and of our experience' (Laudan, 1985, p 153). Similarly, Putnam (1985) did not subscribe to a sharp difference between science and, for example, philosophical, political or ethical knowledge.

Carper seems to feature empirics by using concepts of the received view as well as of the perceived view and within this pattern abstract and theoretical explanations are developed. The distinction between recognition and perception may be the best description of the art of nursing. In the aesthetic part of nursing, patients' or clients' reactions are not only recognized and labelled but their significance to the person is perceived. 'It [the art of nursing] is the knowing of a unique particular rather than an exemplary class' - in relation to man and nursing situations (Carper, 1978, p 18). Personal knowledge in nursing 'is concerned with the knowing, encountering and actualizing of the concrete, individual self' (Carper, 1978, p 18). This mode of knowing is embodied in an authentic personal encounter between the person and the nurse and it supports the integrity and human growth of a person. The ethical pattern of knowing contains questions about what is good and right and what are the obligations in nursing. Carper's conception of knowing in nursing is widening the perspective from the methodological debate mentioned earlier in this section. Carper's notion is directing the investigative efforts into unexplored areas.

Until this point in this chapter, the individual theorists and their conceptual frameworks were mentioned. It is maintained that these separate branches of conceptual frameworks began to form a totality, something which could be called a comprehensive body of knowledge, through two events. The analysis, evaluation and summarizing of published theories by other nurse theorists have been significant for the theoretical development in the discipline of nursing (Fawcett, 1984; Fitzpatrick & Whall, 1983; Meleis, 1985; Parse, 1987; Stevens, 1984). Similarly, the discussion and debate in the nursing press about the need for theories in nursing and about their nature has been a promoting and necessary event on the way to a common understanding within the nursing profession. Instrumental in this development have been journals like Nursing Research, Advances in Nursing Science and Journal of Advanced Nursing which have a wide international audience.

Though the general development of nursing models and theories has dominated the epistemological discourse within nursing, the institutional development certainly provided a framework for nursing research as well and through that activity nursing knowledge has accumulated. That field of knowledge is so vast that summarizing or analysing it as a totality is an impossible task and beyond the scope of this investigation. The outcomes of this scientific activity constitute a significant part of the body of knowledge in nursing. These outcomes appear in the journals mentioned above and in many others, published e.g. as reviews (Werley & Fitzpatrick, 1983; Fitzpatrick, et al., 1989), as proceedings of international research conferences (Sorvettula, 1987; Stinson, et al., 1986) or as a research base for nursing (Wilson-Barnett & Batehup, 1988). A special, though different theme in knowledge development has been the production of a classification system for nursing diagnoses (Gebbie & Lavin, 1975; Gordon, 1985; Kim, 1989).

From the material presented in this section it could be argued that the path followed in nursing has not been an exceptional one if viewed from the epistemological perspective. For instance, according to Laudan (1985, p 144) 'there is a range of levels of generality of scientific theories ranging from laws at the one end to broad conceptual frameworks at the other'. The majority of nursing theories can be categorized as being 'broad conceptual frameworks'. Though it may not be right to state that practice has been primary - in scientific advancement of nursing theory building as such has been emphasized - there has been an attempt to link scientific

development to practice. Also applicable to nursing is Putnam's observation that 'the primary importance of ideas is that they guide practice, that they structure whole forms of life' (Putnam, 1985, p 78). It has not been a characteristic of scientific practice in nursing to corroborate or falsify the theories, but there has been the effort to test them for practical implications (Silva, 1986).

In conclusion, the pattern of knowledge development in nursing emerging from the literature, seemed to contain the following features. At the beginning, nursing was dependent on and influenced by other sciences such as biological, behavioural and social sciences. The institutional development provided gradually circumstances for scientific and other types of intellectual inquiry into nursing by nurses. This process has established a unique knowledge base for nursing. However, it is contended that the institutional development, though as such necessary for nursing, by separating practice, research and education, has prevented a balanced development and thus lessened the impact of knowledge development on direct patient/client care which is the essence of nursing.

In the cognitive history of nursing, broad conceptual constructions have been visible, they have been called frameworks, frames of references, models and/or theories. Fawcett has summarized this development: '...the conceptual model evolved from empirical observations and intuitive insights of scholars and/or from deductions that creatively combined ideas from several fields of inquiry' (Fawcett, 1984, p 4). However, in the cognitive history of nursing, also the inductive approach in knowledge building has been developed. A need for exploration of various ways of knowing in nursing has been justified (cf. Benner, 1984; Carper, 1978, Schön, 1983).

The interrelatedness of the knowledge development with the general development in the profession of nursing seemed evident. Trends in society and health service systems made it necessary for nurses to articulate the inner nature of their service. That resulted in those conceptualizations which were called models and/or theories. Similarly, the aspirations within the nursing community to become a full-fledged profession attached great importance to a scientific body of knowledge. This was expressed by Peplau: 'nursing as a profession...has a social right and a public

obligation to develop nursing science' (Peplau, 1987, p 14). Armiger has summarized this point: 'there exists today an unprecedented need for identification of the uniqueness of nursing science and practice, lest overriding forces in contemporary society lead to disintegration of nursing as a distinct profession' (Armiger, 1974, p 160). Or as the earlier cited philosopher has stated: 'the acquisition of knowledge is a fundamental mode of human action;...it is therefore inseparable from other forms of human practice; and...it is also inseparable from the historicity of these other modes, that is, from their historical change and development' (Wartofsky, 1987, p 358).

2.2.4. How is nursing knowledge acquired?

The roots of nursing knowledge are in clinical practice as e.g. Meleis (1985) has stated. Originally, knowledge gained in practice has been transmitted as a word-of-mouth and it has often been based on authority e.g. in the form of procedure books or on tradition e.g. in the form of past experience. An individual nurse acquired knowledge from her own practice by using methods of trial and error, intuition, inspiration and/or logical reasoning (Wilson, 1985). Obviously, because of curriculum development, the educational system has had an impact on nursing knowledge through the accumulation and reordering of the subject matter. In its quest for scientific credibility, nursing was influenced by established sciences such as biological, behavioural and social sciences. As a part of the institutional development, research training took place under established systems and as a price of learning methodology, conceptualizations and ideas strange to nursing were imported from the basic sciences (Conant, 1968; Watson, 1981). Thus, as a part of the cognitive development, the roots of nursing knowledge are also found in the basic sciences as e.g. Peplau (1987) has maintained. Biological, behavioural and social sciences have had an impact on nursing knowledge due to the fact that concepts and conceptual constructs have been drawn from them and through various intellectual processes have become integrated in the body of nursing knowledge (Walker & Avant, 1988).

Today acquisition of nursing knowledge can be discussed within 'the conceptual-theoretical systems of nursing knowledge required for scientific and professional activities' (Fawcett, 1984, p 1). Two ways of knowledge acquisition can be identified in relation to scientific activities, i.e. theory development and research generally and

two ways in relation to professional activities, namely ethical knowledge and knowing in practice. Though the two ways of knowledge acquisition are separated for discussion, in actuality they form a coherent whole. What has been said about the nature of knowledge in nursing in the preceding section, exemplified the outcome of one mode of scientific activity, that of building models and theories for nursing. This activity has been the major organizer of the body of knowledge in nursing. Methodologically, this development has combined induction and deduction, empirical observations and intuition and research may or may not have been a part of the process.

The often cited theory of theories by Dickoff and James illustrated in what ways theorizing in nursing could take place. In that sense, the proposal is a methodological device. Four levels of theories were proposed by Dickoff and James (1968a) and Dickoff, James and Wiedenbach (1968). In the proposed theory of theories, a first level theory exists partly to form the basis for the second level theory which, in its turn, provides a basis for the third level theory and the highest level theory forms the basis for practice.

Factor-isolating theories are invented by identifying and naming concepts which then become the building blocks for the further development of theories. These first level theories began to organize nursing around the concepts (Meleis, 1985). Literature which has introduced nursing concepts in a systematic way can be classified under factor-isolating theories (Byrne & Thompson, 1972; Mitchell, 1973; Norris, 1982). In factor-relating (or situation depicting) theories, relationships between the concepts are built. Examples of these second-level theories could be relating preoperative teaching to postoperative pain, or relating participation in nursing decisions to motivation for self-care, or measures providing orientation to coping in old age. Third-level theories are situation-relating theories. On the whole, third-level theories are causal in the sense that in the empirical world the investigators (in other words, the theorists) have observed certain situations regularly being followed by certain other situations.

None of the previously mentioned levels of theories includes the intention of influencing the empirical world, in other words, the practice of nursing. This influence is the special characteristic of the fourth-level theory which has been called

prescriptive, goal-incorporating or situation-producing theory. There are three elements which characterize the fourth-level theory: (1) the conceptualization of the goal of activity or the desired situation, (2) the conceptualization of the prescription for the activity and (3) a survey list. The third element will require clarification. Firstly, the survey list includes theories from other disciplines if the theorist considers them relevant for the creation of the situation. Secondly, the survey list includes those aspects of the activity which, according to the theorist, are contributing to the production of the situation. The survey list of Dickoff and James includes the following six aspects of activity:

agency, the performer of a given activity,
patiency, the recipient of the activity,
framework, the context of the activity,
terminus, the end point of the activity,
procedure, the protocol of the activity and
dynamics, the source of energy.

This theory of theories which was meant to be a practice theory for theorizers as Dickoff and James (1968b) have noted, exhibits several features which are important in this discussion. The roots of the theory remain in the practice of nursing and through the concept of goal (i.e. one ingredient in the situation-producing theory) the professional purpose is included into the conceptualization. In principle, the theory of theories seems to involve everybody in the profession in the intellectual activity, for instance, through the concept identification and clarification, or through application of the nursing theories. 'Theory is born in practice, is refined in research, and must and can return to practice...' (Dickoff et al., 1968, p 415). Theory of theories does not state any strict methodological constraints and therefore leaves space both for experimental designs and naturalistic inquiry. The issue of nursing theory versus borrowed theory has got a solution as well. Theories from other disciplines 'are building blocks...in the mansion of nursing theory' (Dickoff and James, 1968a, p 202) and they are integrated in the situation-producing theories. When the characteristics of nursing as a science were outlined in the section 2.2.2., it was noted that one way of defining the purpose of science is to feature it as a means for problem-solving. There seems to be a distinct affinity between the notion of problem-solving effectiveness of a given theory and the nature of a situation-producing theory.

Nursing research is a conventional and prime mode of acquiring knowledge in nursing and it depends on the methodological choices to what extent this systematic inquiry is embracing nursing phenomena. It is contended that methodological choices and methods used have taken over and the nature of nursing as an object of scientific and other kinds of intellectual inquiry has been subordinate. According to Chinn and Jacobs (1987) the scientific-empirical approach has been in the past valued in nursing as has been the case in most other disciplines. This method of acquiring knowledge in nursing has now been criticized and alternative patterns have been suggested in nursing literature.

Like Chinn and Jacobs, Meleis has dealt with the phases in the past development where scientific method or logical positivism was simply received by nurses for their scientific endeavour. However, that 'received view' turned out to be an inhibiting factor in knowledge development because it excluded many nursing phenomena. 'Perceived view' has been the other approach to theory building and research whereby characteristics like wholeness, human experience, intuition and subjectivity have been included in scientific practice as researchable entities. Similarly, Munhall (1982) and Oiler (1982) have noted that the nature of nursing and values embodied in it, included many such qualities (e.g. wholism, patient-nurse interaction, importance given to human experience and advocacy) which were in accordance with the phenomenological paradigm and qualitative methods.

On the whole, changes both in nursing and in the philosophy of science have contributed to the methodological views. Through the philosophy of science the epistemological and methodological shift from a positivistic and quantitative approach to nonpositivistic and qualitative methods has been legitimized without abandoning the traditional scientific method (Goodwin & Goodwin, 1984 ; Munhall & Oiler, 1986; Omery, 1983; Tinkle & Beaton, 1983). Gortner believed that 'the profession surely can accomodate multiple paradigms (analytic, humanistic) and modes of inquiry (naturalistic, experimental, historical)' (Gortner, 1983, p 6). Moccia, however, did not conceive unproblematic compromises suggested between qualitative and quantitative methodologies in nursing research. The reason for the warning was the fact that in choosing a particular methodology an investigator was implicitly also making other choices. These other choices included matters like the assumptions about

the nature and purpose of knowledge and science and according to Moccia, this situation called for more awareness of matters involved in the philosophy of science (Moccia, 1988).

This shift from positivistic philosophy of science to phenomenology and qualitative research strategies generally, exemplified by Chinn and Jacobs, is evident also in the content of books on nursing research methods where material introducing phenomenological approaches and qualitative methods now appears (Chenitz & Swanson, 1986; Field & Morse, 1985; Leininger, 1985; Munhall & Oiler, 1986).

Two categories of knowledge acquisition were noted in relation to professional activities and they concerned ethical knowledge and knowing in practice. Moral philosophy and ethics have been the bases for the work of nurse ethicists (Curtin & Flaherty, 1982; Davis & Aroskar, 1983; Steele & Harmon, 1983). Another field of knowledge belonging to the realm of ethics emerged from nursing practice situations where ethical dilemmas have been encountered. A good example of this type of knowledge is the publication by the ICN, The Nurse's Dilemma (1977) which was based on descriptions of concrete practice situations where ethical code and reality were not compatible.

The profession of nursing has begun to appreciate knowledge generated through clinical practice and has built upon increasing experience. A thread is visible in nursing literature (e.g. Agan, 1987; Benner, 1983; Benner & Wrubel, 1982), which draws attention to those rich and varied ways of 'knowing' in nursing, which were submerged during the period when the whole scientific establishment was constructed according to the norms of the time (Watson, 1981). This mode of acquiring knowledge is closely related to the understanding that nursing is an applied or practice discipline. Benner has stated that from this vantage point, knowledge development includes 'extending practical knowledge...through theory-based scientific investigations' - i.e. through the approach discussed earlier in this section - but also 'through the charting of the existent "know-how" developed through clinical experience...' (Benner, 1984, p 3). The latter approach calls for different kinds of methods for documenting nursing knowledge and it will involve clinicians in

knowledge development to the extent unexperienced before. For that development, the term 'epistemology of practice' will be appropriate.

2.2.5. Epistemological assumptions and this study

That theory development has been an essential intellectual activity in the discipline of nursing is here accepted as a descriptive fact. The accounts of early theorists clearly indicated that the social situation, in other words, the general developments in the health field and in the sciences related to that development had created a challenge to nursing and made it necessary to describe nursing as a conceptual and functional totality (as opposed to a series of separate tasks). On the other hand, aspirations concerning future development had created a readiness in the profession of nursing to encounter that challenge. Theory development was not purely an academic exercise but it took place under certain social pressure and it was facilitated by professional aspirations. Some of the early conceptualizations were intended as urgent measures to support nursing in the face of change rather than as nursing theories per se, though they are presently analysed and assessed as theories.

Today, the need for a theoretical foundation for nursing is not questioned though methodological approaches are debated. It may be, after all, that methodological issues should not be given the primary importance; instead, broader epistemological issues about what constitutes scientific and nonscientific knowledge in nursing should be tackled first. There are signs of an attitude which tries to avoid the assertion that some nursing scholars have an incorrect understanding about proper methodology for application to nursing. The following quotation of Meleis exemplifies that attitude: 'Nursing theory is then defined as an articulated and communicated conceptualization of invented or discovered reality ... in or pertaining to nursing for the purpose of describing, explaining, predicting, or prescribing nursing care' (Meleis, 1985, p 29).

The possibly conflicting assumptions underlying theories and models have not prevented the nursing community from exploring and applying different theories and it is difficult to estimate what kind of impact this has had on nursing as a totality. Theoretical pluralism has been considered to be a mode which does not block future

development. However, the level of theoretical development seems to suggest that the epistemological and ontological issues need to be addressed in more depth. That may even be the way forward in intellectual development.

The epistemological assumptions underlying this study consider nursing as a discipline where practice is primary and therefore the purpose of science is to generate knowledge for action, or to make recommendations for action. Nursing's main concern is man in his environment, and health and illness, therefore nursing research should be methodologically open both to approaches of biological and social sciences along with humanities, and to qualitative and quantitative methods. Because the focus of this study is a unique programme and therefore is a singular case, a major effort has been made to link it historically, conceptually, and theoretically to the scientific environment outlined in this section.

2.3. A professional perspective on nursing

In this section a general picture will be outlined of the course of development of nursing. The perspective here is a professional one. The discussion about epistemology of nursing in the preceding section is complementary to the present account. It is assumed that factors which have shaped and continue to shape the nature of nursing and its institutions, have had an impact on the Nursing Programme. Therefore, the natural development in nursing as a discipline and as a service to people, provides a perspective in which the Programme and its achievements can be understood. The development of nursing in societies has been influenced by various internal and external factors in the profession and the impetus for change or resistance to change has accordingly come from different sources. The external factors are discussed first; they include educational issues and the general position of nursing in health service field. The internal factors are those which have been initiated and often also controlled by nurses themselves.

Nursing has its roots in the general development of societies. Nursing is seen to have evolved from very early phases of human history when - what is now perceived as separate professions - the evolution of nursing and medicine was interwoven. Nursing

has its roots in mothering and nurturing seen as domestic arts, in assuming an obligation to care for family members and other fellow human beings, in Classical Greece, Byzantine and Christian thoughts, and in wise women and women healers (Abdellah, 1972, Ehrenreich & English, 1973; Lanara, 1981; Reverby, 1987). Even such a short reference to the remote past of nursing is essential because the past reveals the very essence of nursing, that of humane care and help to people in their various life situations when they could not function independently. It may be that the low status nursing continues to have, is attributable to those same characteristics which are fundamental in terms of human life but different from the medical interest. Discussion after these remarks concentrates on more recent development in nursing.

Nursing services have clearly responded to the recognized needs of people. Examples of that are Poor Law Nursing in Britain (White, 1978) or public health nursing in Finland (Siivola, 1984) and Ashley (1976) who has shown how community nurses operated as social reformers. One central theme in social development, that of the status of woman in society, has been almost parallel to the developments in nursing, which is still a female dominated profession (e.g. Ashley, 1976; White, 1978). Nahm has summarized this view by stating that 'problems are associated with the fact that nursing has been primarily a woman's profession with a long history of service and self-sacrifice' (Nahm, 1982, p 15).

Home nursing and community nursing could claim the precedence over institutional nursing in the long evolution of nursing. However, the fact that hospitals have been the major scene of nursing history, has brought special features to the development: nursing has grown together with medicine, shaped by it, shadowed by it, and among other things this has contributed to the subordinate role of nursing. Lovell (1980) argued that the personal and professional identity of nurses has been dictated by outside forces and this author considered it important that nurses become aware of it. Needs of hospitals and the technological development of medicine have been major factors in shaping the pattern and extent of specialization in nursing. The bureaucratic nature of hospitals has influenced the concept of nursing management and the establishment of hierarchical structures. In the course of development, as nursing was more and more directed towards becoming a profession, the bureaucratic institutional framework, governed by medicine and hospital administration, began to be too restrictive and efforts for receiving more autonomy were initiated. This autonomy was

required - and still is required - for enabling nurses to assume accountability to their patients and clients, and consequently, to control their own practice (Fawcett, 1980; Maas & Jacox, 1977).

Tradition in nursing education, especially the apprenticeship system (Ashley, 1976; White, 1978) has been an important denominator. Pupil nurses or student nurses have been an essential part of the nursing labour force. In those circumstances, their educational needs could not have been fully appreciated and more importantly, nursing practice could not be advanced. As late as in the first half of this century in Britain 'the trained nurse never seems to have been employed to give bedside nursing care as a primary function' (White, 1978, p 215). This pattern is sustained in further education which has taken nurses away from direct patient contact. The low status attached to nursing in society has kept educational qualifications for nursing at a low level, which has placed great restrictions on the development of nursing services. Constant drive for better education among nurses has been a feature in the history. There has been a deeply felt need for better education due to the dynamic, complex and unique nursing situations which require a command of a wide knowledge base, moral reasoning and professional skills. Nurses have compared themselves with their fellow-workers who have academic preparation. One of the arguments for better education and particularly for university preparation, has been the desire to be educationally equal with the other health team members.

The general development in nursing has led some nursing authors to very bitter conclusions. Ashley argued that 'The study of nursing's development in the United States is a study of overwhelming obstacles and lack of progress, of discrimination and exploitation' (Ashley, 1976, p. ix). White has given a similar account from the UK:

The country simply took their nurses for granted: they exploited their sense of vocation, neglected their professional education, overworked them, underpaid them, applauded them at times of crisis and undermined them in normal times. (White, 1978, p 210)

There are other types of views as well. The concluding remarks made by Fitzpatrick in her historical account on professionalism read:

The profession has never become discouraged by the obstacles it encountered but rather continued to pursue the steps necessary to reach a greater appreciation of itself, a better understanding of its problems, and a means to facilitate action. (Fitzpatrick, 1983, p 261)

Indeed, the internal factors, i.e. decisions made within nursing, have shaped nursing. Significant decisions in the past have been the separation of nursing from religious institutions, and its affiliation with hospitals, and the decision to place nursing under the medical authority (Abdellah, 1972; Palmer, 1983). It is evident that the visible path of nursing's development can be said to indicate the aspiration to become a profession. Moloney (1986) has suggested that in nursing, its development should be measured against the various criteria of professionalism, whereas Styles (1982) has questioned the usefulness of professional inventories. She has argued that

The energy that has been and continues to be consumed in the debates on nursing's professionalism, if converted into electricity, would probably heat, cool, and light our nursing schools for eternity. (Styles, 1982, p 54)

By the somewhat invisible side of the development, reference is made to the clinical practice area from where the legitimacy of being a profession has to be sought. A varied range of policies - most probably intentional ones - has fostered the distancing of the vanguard of development from the clinical practice. This has taken place e.g. by promoting managerialism as a paradigm for nursing, in other words, promotion and career development have taken nurses away from direct patient and client contact, while management as such became an image of nursing. Inherent in that development has been the hierarchical management pattern with many command levels (Johnson, 1959; White, 1985). However, there has also been efforts to create a clinical ladder which would encourage nurses, who have an extensive knowledge of nursing and who have developed special skills, to stay near to the patient and client (Bracken & Christman, 1978; Christman, 1978; Ulsafer-Van Lanen, 1981).

The knowledge development in the discipline of nursing is also an instance of decisions made by nurses. It has not been only beneficial that nursing identified itself as a science at the stage of its development when it was very much dependent on

behavioural and social sciences. It created some kind of distortion of the course of development, because the intellectual interest was more guided by the established sciences than by the profound patterns of knowing in nursing. Most probably this aspiration of being scientific has delayed the discovery of that huge experiential and intellectual resource which nursing has in its practitioners. If the educational system had widely and systematically shared the products of knowledge development, problems would have been smaller. Yet, too often those who render direct nursing care have been least educated and education along with the career paths have guided practitioners away from practice.

At any given time, there seems to have been one or two central themes which have attracted wide interest and have been given great importance as promoters of the development in nursing. Conceptualizing nursing and related theory development has been one of the themes. The emphasis on nursing research has been another (e.g. Norton, 1988; Report of the Committee on Nursing, 1972). Similar themes - though in another dimension - have been and continue to be the nursing process, development of the classification of nursing diagnoses, quality assurance and primary nursing.

The way nurses have collaborated internationally provides insight into nursing as a whole. The International Council of Nurses (ICN) is a world-wide supporter of the development of nursing. It provides a forum for discussion and debate and based on them, for policy-making. The Workgroup of European Nurse-Researchers (WENR) established in 1978, is probably the most recent example. In WENR, research is seen as a vehicle to promote nursing. Because of the divergence of the level of research developments in the European scale, the group has made an effort to support beginners in research but on the other hand to ensure the academic standard of nursing research (Workgroup of European Nurse-Researchers, 1985). A good political example is the European Community which has provided a platform for nurses to discuss and to make policy decisions in nursing education (Quinn 1980). In Europe one of the key driving forces in nursing's development has been the World Health Organization which lately has extended its collaboration from the government level to various kinds of nursing institutions and individual nurses in those institutions (Pflegeforschung für eine bessere Krankenpflege, 1986; WHO, 1987). Through its recommendations, WHO has attempted to provide assistance to nursing (Stussi, 1986).

In the epistemological discussion, reference was made to the extensive efforts to further theoretical development in nursing. In the 1960s and 1970s several aspects of nursing were developed supported by fairly extensive regional or national efforts. Four examples of such projects, later to be discussed, are included in this text for comparison. The WHO Medium-Term Programme in Nursing/Midwifery in Europe (1976-1983) as an international effort, as well as its implementation in Finland, seemed to have some similarities with these projects.

In the study about nursing and nursing education by the National Commission in the USA, nursing as a whole was in focus, the project was nationwide, and its goal was very similar to the purpose of the Nursing Programme. The National Commission (Lysaught, 1970, p 11) stated the objectives of their study: 'How can we improve the delivery of health care to the...people, particularly through the analysis and improvement of nursing and nursing education'. The efforts to support nursing research on a regional basis, reported by Krueger, Nelson and Wolanin (1978), was another example. In this project, the ultimate goal was to improve the quality of nursing offered to people and this six-year project was able to demonstrate the feasibility of promoting clinical research by combining resources from educational and service institutions. The third example from the USA was the CURN Project (Conduct and Utilization of Research in Nursing) in which an attempt was made to close the gap between research and practice which were seen to be methodologically dissimilar (Haller et al., 1979; Horsley et al., 1983; also King et al., 1981). This gap-closing procedure included a comparison between practice and existing research findings on carefully identified areas and development of innovation protocols on areas where research had suggested changes in practice. The CURN Project produced ten innovation protocols and the project can be considered to have given one model for advancement of knowledge utilization.

The early development of nursing research in the UK was supported by a project called The Study of Nursing Care. This six-year project for which a special support structure was established, was mainly concerned with the quality of nursing care; it aimed at developing research based instruments (measuring tools) for everyday nursing practice. This project which produced twelve research reports, provided a

group of nurses with an opportunity to acquire research skills and to pursue academic studies (Inman, 1975).

2.4. Evaluation perspectives of the study

2.4.1. Three approaches to service evaluation

When the Nursing Programme was introduced to the Participating Centres in Finland, it was stated that in the programme, evaluation would be developed by focussing on outcome, process and structure. Logically those three evaluation perspectives were seen as parts of the nursing process and they were described fairly briefly. Because that evaluation strategy, originally introduced by Donabedian (1966) as three approaches to evaluation and later employed in nursing and health services generally, had shaped the evaluative thinking in the Programme from the very beginning, the same strategy has been adopted to guide that part of the evaluation which has focussed on nursing services. However, not only the previous use but also the characteristics of this evaluation strategy made it suitable for this study.

The origin of this widely spread, and long lived, evaluation strategy was an article by Donabedian in The Milbank Memorial Fund Quarterly in 1966, which focussed on the quality of medical care. This article did not necessarily give the impression that a distinct evaluation method was emerging. And indeed, in a commentary, Donabedian himself has said: 'I am impressed, ...by the remarkable vitality and durability of the structure-process-outcome paradigm...', but in the same connection he has also seen the reason to wonder at 'the many misunderstandings it seems capable of producing' (Donabedian, 1983, p 367). This method or strategy has many names. As can be seen from the preceding quotation, the fashionable 'paradigm' was used; among the other names are 'trilogy' (Donabedian, 1982), 'trichotomy' (Donabedian, 1976a), 'framework' (Huntley et al., 1976), and 'approaches to assessment' (Donabedian, 1966).

Donabedian's three approaches to evaluation were to some extent based on the concepts previously developed by Sheps (1955), whose suggestion for quality

assessment included: (1) prerequisites or desiderata for adequate care, (2) elements of performance, (3) effects of care and (4) clinical evaluation. Donabedian's formulation renamed the first one 'structure', it combined the second and fourth as 'process', and Donabedian's 'outcome' was synonymous with care.

The relationship between Donabedian and De Geyndt is somewhat contentious. De Geyndt's analysis was published in 1970, and it suggested the assessment of content, process, structure, outcome and impact. Under content, medical practice was evaluated and process evaluation referred to the practice of other health workers as well. Assessment of the outcome referred to the end results in individuals or groups of individuals, whereas impact assessment was seen to deal with the broad health policy goals and the health of a nation. Although De Geyndt has been listed as an author whose work is based on Donabedian (1982), as it appeared in the article, De Geyndt was not developing Donabedian's evaluation strategy but offering his own.

In the comparison of evaluation research and testing of situation-producing theories, Diers (1979) has seen connections between Donabedian's approaches and the content of situation-producing theory as proposed by Dickoff and James (1968). Diers suggested that 'structure' might be equivalent to 'framework', 'process' was similar to 'procedure' with some flavour of 'dynamics', and 'patency' and 'terminus' would form the 'outcome'.

For the purposes of this study, the exploration of two integrated themes has been relevant. Firstly, clarification of the concept of quality is an important precondition for any kind of evaluation and, secondly, the content and interrelationship of the three approaches to evaluation, those of structure, process and outcome, will need elaboration.

Donabedian has dealt with the concept of quality in several connections both in relation to medical care and health care generally (1966; 1968; 1979; 1982) and in discussion about the quality of nursing (1969; 1976a). Quality is not a homogenous and self-evident composition of characteristics of health services, but both a conceptual and operational definition of quality has to be worked out for evaluation to take place. First

of all, the attributes of quality are value judgments. Identifying the values is not, however, an arbitrary matter. Those values which will become a part of a given quality assessment process reflect the values held in a particular health service system and in the society at large.

Quality is a property, attribute or ingredient of some predetermined aspect (or evaluation dimension) of health care. In evaluation, an agreement has to be reached about these aspects which may vary depending, for instance, on the notion of health or the level of analysis, be it individual or society, or patient or health care system. What is quality in those predetermined aspects of health care will be expressed by standards and criteria. They can be considered to form an operational definition. Donabedian has suggested for instance that provider performance and provider-client interaction could be aspects to be evaluated and he has further suggested a 'set of specifications' or, as they are today more generally called, a set of standards and criteria. How the standards and criteria are stated is at any given time dependent for example, on advancement of knowledge, on standards which are acceptable to the leaders of a particular profession and on the scope of practice agreed upon between a particular profession and the society. When quality will be defined it should take into account resources available for the activity reviewed and there will be a constant need for reconsidering such statement of standards (Donabedian, 1968).

Donabedian (e.g. 1979; 1982) suggested that for the purposes of clarification of quality, a division of medical care into technical and interpersonal parts was required. The former referred to the employment of medical science and technology in patient care and quality care will be provided when the application of science and technology has produced maximum benefits and minimum harm to the patient, who will participate in the weighing of benefits and risks. In interpersonal care, quality has been defined differently. General rules in the society which cover human interaction are applied and following those rules will constitute quality. Thus, a unifying concept of quality will include maximizing the welfare of a patient under such conditions where balance between benefits and risks has been reached.

In nursing, the kind of division described above is unnecessary. It is true that medical orders and therefore medical technology are implemented also by using nursing

resources and skills of nurses. However, this type of differentiation into technical and interpersonal parts is foreign to the way nursing is conceptualized. Conventionally nursing is viewed as a totality. Interaction with the patient and client has been at the heart of nursing, and there can be no nursing without that relationship. Through the nursing process, knowledge utilization has been seen to be the integral part of actual nursing and not a separate entity. However, these basic differences between medicine and nursing do not inhibit the use of the evaluation strategy.

When Donabedian addressed the audience at a Conference on Issues in Evaluation Research, organized by the American Nurses' Association in 1975, he presented quite a broad view of quality. This view had three facets: (1) the concept of health, (2) recipients of care and (3) providers of care and the manner in which their contribution has been organized. How health and responsibility for it has been understood would have a great impact on conceptualizing quality and quality assurance as well. Enlarging the concept of health to embrace - in addition to physical health - also psychological and social aspects of health, would increase the quality of care. Recipients of health care may be individuals, groups of individuals or the whole community. Important questions related to quality were, for instance, who had access to health care and how resources were allocated to serve an individual or an aggregate of individuals. The third facet of quality ranged from an individual practitioner to groups of practitioners, to health care programmes and institutions. This facet has brought new attributes to quality, such as continuity of care, coordination of services, and creation of functional teams. Donabedian has shown that when the focus of evaluation has been moved from a receiver-provider unit to the level of population and institutions, complex social issues are faced (Donabedian, 1976a; 1976b).

Regardless of the definition of the concept of quality adopted, the three approaches to evaluation can be employed (Donabedian, 1983). Furthermore, it has been a typical feature of this evaluation strategy that it leaves open what in any given situation should be considered to form the content of structure, process or outcome. However, Donabedian's writings have given enough information for a general picture to be drawn.

Structure has been considered to be fairly stable by nature and information needed for the appraisal of the structure has been usually easily available and in concrete form. In the evaluation of structure the following areas may be considered:

- human resources: qualification, number, distribution and organization of providers of care;
- physical resources: physical setting, tools, equipments, facilities and their adequacy;
- financial resources;
- social and cultural factors; the manner in which health services are organized (e.g. informal and formal organization), operations of programmes and care giving institutions; and
- administrative structure (Donabedian, 1966; 1968; 1969, 1982).

Donabedian (1976a; 1982) has suggested that, when the care given by a provider to an individual is assessed, the process evaluation is appropriate and structure and outcome evaluations in that connection will become indirect measures of quality. The following elements were the focus of the process evaluation:

- social values and ethical norms underlying action;
- capabilities of (medical) science and technology e.g. in the form of published research;
- proper application of available knowledge: specification of the health situation; justification of diagnosis and therapy, choice of objectives, choice of methods, technical competence, i.e. skillful execution of methods;
- decisions and actions of the providers of care;
- acceptability of care to the recipient;
- evidence of preventive management in health and illness; and
- coordination and continuity of care (Donabedian, 1966; 1968; 1976a; 1982).

'Outcomes, by and large, remain the ultimate validators of the effectiveness and quality...' (1966, p 169), was Donabedian's early conceptualization. Later (1983) he does not believe that outcome evaluation would be a more valid measure of quality than process evaluation. This third approach, outcome evaluation, has been focussed for instance on the following details:

- end results, such as recovery, restoration of function and survival;

- health, welfare and client satisfaction;
- a change in the current and future health status of a person;
- improvement of physical, social and psychological function; and
- patient attitudes, health related knowledge and behavioural changes related to that knowledge (Donabedian, 1966; 1968; 1969; 1976a; 1982).

The statement about the ultimacy of outcomes has been repeated by, for instance, Jelinek, Haussman, Hegyvary and Neuman (1975). However, based on their ambitious project for developing methodology for quality monitoring, these authors have suggested that for day-to-day decision-making and management of nursing, process evaluation is important. Bloch (1975) has suggested the combination of process and outcome evaluation.

Donabedian (1982, p71) has asserted that 'there is a fundamental functional relationship between the three elements' and the relationship has been depicted: Structure -> Process -> Outcome. That relationship has justified the three assessment approaches. However, none of them has been considered to be a superior measure of quality in all instances, '... structure, process and outcome are the servants of quality assessment, not its masters' (Donabedian, 1983, p 368). The expression 'three approaches to evaluation' has been used in this study to indicate that the evaluation strategy employed does not allow the establishment of any causal relationships between the three elements. It is, however, assumed that some kind of interrelationship exists.

To find out, how these three approaches to evaluation, especially Donabedian's first article from 1966, have been used in other studies and explorations of evaluation issues, a review of literature has been made. Based on this focus, the literature can be grouped into four categories:

1. Broad health service issues, such as organization of health care (Reinhard, 1973) or the impact of regulation on quality of services (Covell, 1980).
2. Several aspects of health services, for example mental health (Tash & Stahler, 1984), medical care in different type of settings (Huntley et al., 1976), nursing care (Padilla & Grant, 1982), dental services (Demby & Rosentahl, 1978) and nursing homes (Levey et al., 1973; Day & Klein, 1987).

3. Consumer perspective or consumer satisfaction (Lebow, 1974; Kelman, 1976; Stewart et al., 1985).
4. Quality assurance specifically (Green & Attkisson, 1984; Sanazaro & Worth, 1978; Brook et al., 1976).

The kind of role Donabedian's evaluation approaches have had in the evaluation of health services can be pictured as follows. It seems to be plausible to argue that Donabedian is an exponent of evaluation of health care and a standard reference in quality and evaluation issues. There are other authors who have explored Donabedian's evaluation suggestion in greater depth. Reinhardt (1973) and Nagi (1975) are instances of authors who have drawn attention to quality. Green and Attkisson (1984) and Schlenker (1986) have given the impression that structure, process and outcome as such would constitute quality and that notion might be one of the misunderstandings which Donabedian has referred to. However, the manner in which the analysis has progressed in these articles does not indicate any distortion.

Structure, process and outcome approaches have shaped theoretical perspectives and studies as well. Pollock (1987) has used it to structure the literature review. Lane and Kelman (1975) have suggested that all three approaches should be used in the assessment of maternity care and Amonoo-Lartson, Alpaugh-Ojermark and Neumann (1985), after considering all approaches, have employed process evaluation in primary health care. Discussion about the three approaches in the literature has clearly suggested that what is dealt with under structure, process or outcome, depends on the area in which the approaches are applied.

The evaluation practice which has, in one form or other, taken Donabedian's early writing as a source of ideas, seems to present a distinct pattern. Detailed analysis related to Donabedian has suggested that structure, process and outcome approaches, as well as discussion about the broader evaluation issues by Donabedian, have been a constant source of stimulation in the field of evaluation and furthermore, they have become self-evident elements of quality assurance (Bloch, 1980; Brook et al., 1976; McAuliffe, 1979; Smeltzer, 1988). It may even be that when reading the material presented around the three approaches to evaluation, one is reading an essential part of the history of quality assurance, which is an important factor of modern health

services (WHO, 1986) and an area of rapid development also in nursing (Giovannetti et al., 1986; WHO, 1979a; Pelkonen & Sorvettula, 1988).

It is difficult to find any real criticism of this evaluation strategy in the literature. In this study the idea of the three approaches to evaluation has been considered to be too loose to be called a model. But seemingly its comprehensiveness has been the strength of these approaches; it has allowed the inclusion of essential aspects into evaluation at any given instance. The result has been that the laborious phases, i.e. the establishment of standards and criteria as well as specific evaluation methods have been left to be developed by the users. The three approaches to evaluation have, more than anything else, created the pattern of thought employed in evaluation (e.g. Hamric, 1983) and the broader discussion around the concepts has promoted evaluation in health care.

The interrelationship between the three elements has been problematic in nursing (Downs, 1980; Hegyvary et al., 1976; Lang & Clinton, 1984). We have to believe that the manner in which nursing is offered has some impact on the outcomes and it is also reasonable to believe that, for example, the physical environment or proper inservice education have an impact on the manner in which nursing care is delivered. In actual evaluation practice, however, these three elements are often dealt with separately. Furthermore, the concept of quality, analysis of which is essential in evaluation, has not been explicitly linked to the approaches. It is argued here that the nature of this evaluation strategy has made it an everyday working tool and, because of its very nature, it has attracted or initiated too little investigation which could have clarified the relationships inherent in the strategy. Lack of research attached to evaluation practice has been observed by Bloch (1980) and Giovannetti, Kerr, Bay and Buchan (1986) as well. In nursing research, one of the challenges will be to study the validity of the argument, that outcome measures would be the ultimate validators of quality.

In summary, the three approaches to evaluation, those of structure, process and outcome will be employed. They are considered to refer to the concepts and practices which today are established elements in evaluation and quality assurance. No efforts

will be made to demonstrate a causal relationship between factors represented by the approaches.

2.4.2. Programme evaluation research

2.4.2.1. Introduction

The purpose of this section is to introduce programme evaluation research. This will be done by approaching the topic from diverse perspectives. Firstly, it will be shown how evaluation issues have been approached in nursing, highlighted with some examples. Secondly, programme evaluation as a strategy for assessing social programmes will be introduced. In this connection, reference will be made to the methodological debate within the evaluation community; this debate includes similar concerns and arguments as discussed in regard to the epistemology of nursing. Thirdly, a set of general models for programme evaluation will be described. This discussion will focus on specific strategies in programme evaluation and outline the models which have had a major impact on the present study. Fourthly, in addition to the theoretical discussion about programme evaluation, this research approach is highlighted with actual research examples as well as with specific models developed for programme evaluation found in the literature.

2.4.2.2. Evaluation issues in nursing

Evaluation research appeared in some nursing research textbooks as one research design. Evaluation research has been considered to be an approach whereby it was possible to find out whether or not a programme, policy or practice was doing what it was supposed to do (LoBiondo-Wood & Haber, 1986; Polit & Hungler, 1987; Seaman, 1987). Diers' textbook on nursing research (1979) was an exception in that, in this book, the approach was more analytical than in others. The frame for the analysis in Diers' textbook was the contrast between situation-producing theory testing and evaluation research. This contrast suggested that evaluation research was connected with policy decisions and was a political process in character, whereas,

theory testing was a conceptual process. According to Diers, in evaluation research or programme evaluation the purpose was not to develop theory, as programme evaluation was rarely built upon any framework and furthermore, the programmes themselves have not regularly been based on the theoretical grounds which could prescribe the actions for goal achievement. Diers has noted that those factors had an impact on generalizability of the findings. For Diers, the goal was preset and the intention was to show how a given programme was reaching its goals; whereas, in theory testing the goal was a part of the theory and therefore was tested as well.

Within the domain of nursing, there are several concepts and practices which incorporate the notion of evaluation and exhibit a wide range of evaluative approaches. The examples include: (1) evaluation in nursing education, (2) the nursing process (or process of nursing or clinical problem-solving), (3) nursing quality assurance and different types of audits, (4) programme evaluation and (5) evaluation of various aspects of nursing with or without research input. Evaluation in nursing education as well as programme evaluation will be discussed in some detail later in this chapter. Here reference is made to the other categories mentioned above.

On the level of an individual, the nursing process includes evaluation as a fourth phase and in principle evaluation is accomplished by comparing client-centered objectives with client outcomes. This evaluation is based on clinical judgement though research may have contributed to the methods employed. As regards quality assurance, evaluation is the first step in any quality assurance programme (and another step is making corrections) and though quality assurance may be research based, as an actual practice it can be either professionally or scientifically directed. As a part of a quality assurance programme, the quality of the structure of nursing service, its process, or its outcomes may be assessed - as was noted when Donabedian's work was introduced in the previous sub-section. It is the outcome assurance which particularly benefits from research based knowledge. Application of the nursing process may be a part of the quality assurance programme. There seems to be some connection between the programme evaluation as described in this section and the recent development of nursing quality assurance (Driever & Birenbaum, 1988; Pelletier & Poster, 1988).

The general statements of the significance of evaluation in nursing accommodate a very broad inclination towards regular evaluation of nursing practice (Bergman, 1982; Hockey, 1977; WHO, 1979a). The roots of evaluation research in nursing seem not to be in programme evaluation as described in this section. It has been the firm belief in the importance of assuring quality of nursing - mostly on the level of an individual - and accountability issues, which have been the driving forces in the development of evaluation research in nursing. Lang and Clinton (1983) have added to the influential factors also concerns of the public for the quality of services they receive, economic factors, the nature of nursing as a scientific discipline, and the growing activity of nurses in the field of policy-making. Discussion about Donabedian's structure, process and outcome approaches is also an instance of this general belief in the importance of evaluation (Bloch, 1975). Thus, this area in evaluation includes a varied range of evaluation purposes and methodologies and emphasis is always on a systematic approach. Research methods may or may not have been used to accomplish this kind of evaluation.

Indeed, it seems to be a custom to explain evaluation by contrasting it with research (Downs, 1980; Holzemer, 1980; Popham, 1975; Worthen & Sanders, 1973). This type of dichotomizing is useful in pointing out the salient features of evaluation; but it does not give any overall conceptualization of evaluation. It does not suggest what programme evaluation research might be. Furthermore, this type of dichotomizing seems to be based mainly on a positivistic research orientation and excludes a naturalistic research orientation. It is suggested here that research can be conducted for evaluative purposes, and evaluation can employ principles of scientific research as they are broadly understood.

The intention here is not to give a complete picture of the use of evaluation in nursing, only some features of the focus and methodology are given. It is obvious that research methodology can be used for evaluation purposes and, under certain conditions, experimental design may be the most appropriate (Overton & Stinson, 1977). Systematic evaluation of computer software by using objective criteria and subjective judgment has been developed (Nelsen, et al., 1985). A systematic evaluation approach has been employed in selecting and purchasing different kinds of products for health care institutions (Larson & Maciorowski, 1986; Willington, et al., 1981). Olade (1984) evaluated the possibility of adopting a developmental screening test from one

culture to the other by using a slightly modified test in a new cultural environment. Cox (1985) and Majesky, Brester and Nishio (1978) evaluated a new measure introduced to nursing. The former was a psychometric evaluation of a health self-determinism index, of which content and face validity and item clarity were observed and randomized sample was used to test the index. The latter was an instrument for measuring nursing care complications. In developing specific nursing interventions, evaluation in the form of an experiment has been used (Ventura et al., 1984). Evaluation of the impact of the organization of work in the form of primary nursing (Bailey & Mayer, 1980; Ventura et al., 1982) and patient allocation (Chavasse, 1981) are also examples of the use of evaluation approaches. The utilization of evaluation approaches with or without research input shows variability, however, a combining feature seems to be the need for solving some practical problem.

Each evaluation category in nursing may be considered to be fairly well developed conceptually and methodologically - even evaluation with or without research input has distinct shape - but there is not yet any device which would theoretically combine them - if that were considered desirable. In the efforts to provide clarity for the practice and research areas which come under the umbrella concept of evaluation, some confusion between various aspects of evaluation has been found in nursing literature (Luker, 1981; Woody, 1980), but also succesful clarification has appeared (Schmitt, 1986). There has been enough evidence to suggest that conceptual and methodological clarity do not yet characterize this whole area, however, the importance of various aspects of evaluation has been well documented and systematic evaluation has been given priority in nursing.

Evaluation always includes a significant ethical component, or rather, the whole process originates from values. It is very evident for instance when evaluating the care given to a patient or when planning a quality assurance programme and establishing standards for it. It is equally important in product evaluation where economic and human values are weighed against each other. It may be argued that there are differences in regard to the scope and complexity of knowledge involved in evaluation procedures. This is not to suggest that the impact of knowledge would not be essential in any evaluation instance, it is really the complexity and scope which is different.

2.4.2.3. General background to programme evaluation research

Formal evaluation research belongs in a broader research category titled policy research (Hakim, 1987). Policy research is focussed on organizations and their processes; it is multidisciplinary and multidimensional and seeks to provide a balanced picture of its object. People are approached in their roles and not as individuals. It is believed that at a macro level, causal processes can be followed by employing policy research strategy (Hakim, 1987). This evaluation of the Nursing Programme, in very general terms, belongs in the research tradition called policy research. In their survey, Brown, Tanner and Padrick (1984) have noted that an organization or a group has seldom been the unit of analysis in nursing research and in that regard this study may be contributing to the repertoire of nursing research.

Programme evaluation research began to evolve in the 1960s and 1970s as a reaction to the need to establish whether or not extensive human service programmes, instituted by governments to solve social problems or to promote social development, were reaching their goals. These social programmes were directed against such problems as poverty, lack of education or ill health. Programme evaluation led social scientists to work together with policymakers which has become a special feature of this field of investigation. The Nursing Programme in Finland was also a government programme, designed - not to cure social ills - but to tackle identified weaknesses in nursing and to promote the overall development.

Weiss (1972) wrote one of the early method books for evaluators. In the introductory chapter, the author has characterized programme evaluation in a manner which is not relevant only to the present study but also to the understanding of programme evaluation: 'Evaluation investigates the consequences of dynamic programs that attempt to alter key variables in people's lives. Finding out how successful these efforts have been, and why, can lead to discoveries about basic concepts of human behavior and social structure - if the research is carried out with care and insight' (Weiss, 1972, p viii). Suchman's (1967) book on evaluative research is also a classic work. It introduced several views which have been topics of discussion while programme evaluation has evolved. Among them are: measuring the attainment of identified goals by using scientific methodology, finding a controlled situation for

measurement of the achievement of the objectives as well as negative side-effects and the impact of values in evaluation theory and practice. Baker (1983) has noted that, in the same way as Donabedian's structure-process-outcome approaches have dominated quality of the health services field, Suchman's conceptualization of programme evaluation has had an impact on the programme evaluation field.

Head Start has been a classical example of extensive programmes instituted by the USA government against the ailments of poverty. The programme supported half a million children under school age; due to the poor family background, the cognitive and affective development of those children needed special supportive measures (Abt, 1976). On the local level this programme also involved nurses as coordinators (Ettlinger, 1970) or as providers of services (Larue, 1970). Another example is a nationwide experiment in the USA in the field of mental health (Fairweather et al., 1974). Together 255 mental hospitals participated in the programme which had as its basic idea to create autonomous groups of mental patients, first at the institution and then move the established autonomous groups into community residences.

The Handbook of Evaluation Research (Struening & Guttentag, 1975) was a milestone in the development of evaluation: it codified previously separate psychological, educational and economic projects into a distinct scientific practice, now known as programme evaluation research (Brewer, 1983). In 1976, the Stanford Evaluation Consortium (1976) published its critique of the Handbook. In their review, the evaluators of evaluation research considered the mainstream of evaluator's practice to have been technical and through their comments promoted a more participative approach. Brewer (1983) has used Levine, Solomon, Hellstern and Wollmann (1981) as evidence of the international nature of programme evaluation. In that compilation of texts, Levine (1981) has reported on a pilot analysis of the use of programme evaluation in nine Western countries. In that analysis, programme evaluation was seen to be an administrative tool in the use of governments and evaluation took the form of policy analysis mainly.

The following definition by Patton of programme evaluation research has been adopted for the present study: 'the practice of evaluation involves the systematic collection of information about the activities, characteristics, and outcomes of

programs for use by specific people to reduce uncertainties, improve effectiveness, and make decisions with regard to what those programs are doing and affecting' (Patton, 1987, p 15). Patton has emphasized four points in his definition: (1) collection of information is systematic, (2) information is collected about a great variety of topics, (3) information is for use by particular people and (4) information is supposed to serve several purposes.

The field of programme evaluation research which by its representatives is considered to be a distinct specialized profession, has established standards to guide evaluation practice. Those standards state that evaluation has to demonstrate utility, feasibility, propriety and accuracy (Patton, 1987). The first standard includes the requirement that evaluation has to be useful to some group of people. Feasibility has to be assured, for example, in regard to political climate or practical implementation. The third standard stresses the ethical conduct of evaluation, and the fourth one the technical adequacy of the evaluation practice (Stufflebeam, 1980).

There seems to be at least three roots to the development of programme evaluation research. There has been: (1) evaluation which has taken place in the educational sector and in different types of educational institutions; (2) evaluation of large human service programmes which had as their background serious social problems and which were often targetted towards issues in health, education or social welfare; and (3) evaluation as a part of policy analysis. The literature seems to suggest that as far as the creation of forward moving ideas are concerned, the educational evaluation root may have been the strongest. In the literature, all these areas have been discussed under the same broad titles, i.e. programme evaluation or evaluation research and authors seem to use the two expressions interchangeably. Evaluation research uses methods developed in social sciences. In that respect programme evaluation is not unique and its special nature is established through its purposes and through its links with the planning and decision-making processes.

The notion that the scientific and naturalistic paradigms represent incompatible world views has generated great debate among evaluation researchers. Similarly, debate about quantitative and qualitative methods and about the possibility to work from both orientations or with multiple methods has been documented (e.g. Lincoln, 1985;

Patton, 1982). Two schools of thought can be identified based on the methodological rules applied in programme evaluation. The originally dominant one has employed experimental designs and quantitative measurements and has considered objectivity and replicability to be the keys in successful evaluation (e.g. Riecken & Boruch, 1974; Rossi et al., 1979). Patton (1980) has even argued that at those times, all evaluation problems were answered by administering standardized tests within experimental designs. Riecken and Boruch (1974) with their co-authors viewed experimental design as superior in testing causal hypotheses, but they also argued that the experimental approach will assist in clarifying the nature of social problems. This approach as an exclusive evaluation practice was criticized by the Stanford Evaluation Consortium. The newer school of thought has been in favour of naturalistic evaluation practices, qualitative methods and illumination of a given programme as a whole (Filstead, 1979; Glaser & Backer, 1972; Guba & Lincoln, 1982b; Parlett & Hamilton, 1976). What can be inferred from that kind of methodological shift is that evaluation research has been part of the general reorientation in social sciences and that reorientation has been related to the changing views in the philosophy of science.

Reichardt and Cook (1979) have tried to bring these two methodological camps closer, in other words quantitative and qualitative practices, and they do not see any absolute antagonism between the quantitative and qualitative paradigms or methods. Rather, they have suggested the concomitant use of these two method-types. Lynch (1983) has criticized evaluators, for instance, Reichardt and Cook (1979) for sharp contrasting of qualitative evaluation and randomized experiments, but Lynch has also made an attempt to lessen the polarization by differentiating logically the position of the inquiry on the naturalistic - experimental continuum, the methods applied in data collection and the types of data collected (qualitative, quantitative or both). The suggestion of this author to evaluators was that they 'should consider nontraditional mixes of inquiry, data, and methods...' (Lynch, 1983, p 464).

Hoeffler and Archbold (1983), two nurse-investigators, considered the qualitative - quantitative debate to represent, not only differences in methodological stance but more importantly, differences in paradigms and therefore in the values held by the researchers and the programme staff. These authors gave a kind of balancing role to the qualitative methods in programme evaluation which in its basic approach may rely heavily on the quantitative methods.

There is also another dimension about which opposing views have been presented. One argument has been that the conceptual and methodological sophistication of the programme evaluation, in other words, its scientific ambitions, have to be given great importance. The other argument has given priority to the information needs of the policy-making community (Weiss, 1981a).

2.4.2.4. Models for programme evaluation

To characterize programme evaluation a taxonomy of eight major evaluation models¹ is presented. The taxonomy was developed by House (1978; 1980) and appears to be based on previous classifications (Popham, 1975; Stake, 1976; Worthen & Sanders, 1973) and recognized by other evaluators (Guba & Lincoln, 1982a; Patton, 1982). Compared with the other classifications of the evaluation models, House's taxonomy has the advantage that philosophical underpinnings of the models have been explicated.

Ethical aspects, epistemological decisions and political consequences are the three elements which can be identified as underlying the models (House, 1978). It is the basic nature of the human service programmes (i.e. they aim at making the lot of people better) and of evaluation research (which aims at showing the worth or merit of these programmes) which makes it understandable that ethical considerations are significant. As in investigation generally, explicit epistemological choices are made in programme evaluation. As has been indicated before, human service programmes are often initiated by governments and by definition in such cases, programme evaluation is linked with the decision-making and policy processes. Therefore, political considerations have become ingredients of the models.

¹The term 'model' has been employed in this connection instead of 'approach' which has also appeared in the literature. This has been done to make a clear distinction between Donabedian's approaches to evaluation and models used in programme evaluation.

Having this broad background outlined with ethical, epistemological and political perspectives, the models can be characterized by clarifying the assumptions embedded in them. The assumptions are related to the following four aspects: (1) the audience, (2) consensus assumed, (3) methodology and (4) expected outcome. The models from 1 to 8 in the taxonomy are related so that the following statements apply to the assumptions. When it is moved from the first model to the eighth model

- the audience is less elitist and more democratic,
- less consensus is assumed on the programme elements,
- the study is employing less objective and more subjective methodologies and
- the expected outcome is changing from social efficiency to personal understanding.

The various models have provided a background for this particular evaluation. Though following none of the models exclusively, the investigation has drawn ideas from several. This means that the models have been employed as suggested by Stufflebeam (1980) when he noted that the models are not intended to be taken literally but rather to be used as tools or as providers of a perspective. The decision-making model, the art criticism model and the case study model have served particularly as background for constructing the design for this study. Programme goal has not been ignored though it has not been employed as an organizer, rather it has been conceptualized as being an integral part of the programme and therefore would be evaluated as well. The three models selected to guide this study were considered to be compatible with the mission of the present study. The models are presented by the work of their major exponents. Because each model in the taxonomy developed by House is a broad category, the salient features of the whole category are presented as well. This is done by using the audience, consensus assumed, methodology and expected outcomes as descriptors. The presentation of the taxonomy includes a more detailed description of the three models which form the background of the design for the present study.

1. The Systems Analysis Model

Cost-benefit analysis is an important part of this model which is addressed to the economists and managers. The model assumes an agreement on programme goals and it aims at revealing the cause and effect relationship. The task of an evaluator is to produce output measures and by using statistical analysis relate the outcomes to the programmes or policies concerned. Social experimentation, quantitative data,

objectivity and replicability have a high priority and social efficiency is the expected outcome. The major promoter of the Systems Analysis Model has been Rivlin (House, 1978;1980; Rossi et al., 1979).

2. The Goal-Based or Objectives -Oriented Model

Managers and psychologists form the major audience for this model. Central to the model is the idea that the data collected by the evaluator are supposed to show whether or not the prestated goals have been achieved. Thus, the model requires an agreement on the goals. Behavioural objectives and achievement tests are important in the methodology. According to this model, reasoning and operations in evaluation progress through the following stages: (1) objectives are stated, (2) data are collected to show how objectives are met, (3) differences between objectives and outcomes are considered and (4) final judgments are made (Stake, 1967). The outcome is expected to be productivity and accountability. Tyler (Tyler et al.,1969) has been the major promoter of the Goal-Based Model (Guba & Lincoln, 1982a; House, 1978;1980).

3. The Decision-Making Model

Though evaluation research is typically connected with decision-making, decision-making constitutes a separate model as well. This model combines evaluation strategies systematically with decision-making. It was Cronbach (1963), one of the early evaluation theorists, who drew attention to the 'programmatic decisions' for which evaluation in education was used. Stufflebeam has been one of the major promoters of the Decision-Making Model. This model is illustrated by using Stufflebeam's Context-Input-Process-Product model or the CIPP evaluation model as an example (Stufflebeam et al., 1971; Worthen & Sanders, 1973). The key concepts of the CIPP model are: (1) definition of evaluation, (2) decision setting, (3) types of decisions, (4) types of evaluation and (5) steps in the process of evaluation.

Stufflebeam defined evaluation as a process of receiving useful information, for judging decision alternatives, by delineating, obtaining, and providing (Stufflebeam et al., 1971). Decision setting is described with two continua: (1) with the extent of change involved in a given programme and (2) with the extent of information needed to support the intended change. Consequently, decision settings may exhibit utopian (mostly theoretical category), innovative, developmental or restorative characteristics.

The CIPP model includes four types of decisions about the programme and four types of evaluations in the service of decision-making. Context evaluation supports planning decisions in the identification of objectives. Input evaluation serves structuring decisions while the design for a programme is considered. Process evaluation is related to implementing decisions by which the programme performance is controlled. Finally, product evaluation serves recycling decisions to judge the programme achievements. Steps in the process of evaluation are those mentioned in the definition of evaluation, namely, delineating, obtaining and providing. These three elements are considered to form the basis of the methodology. Delineating means that the information needs are identified; collecting and analysing data are called obtaining and providing, as a step in evaluation, refers to the production of information in an appropriate form.

The decision-making category in the taxonomy is summarized according to House (1978; 1980): the evaluation is addressed to the decision-makers, especially administrators; it assumes agreement on general goals; questionnaires, interviews and natural variation are typical in the methodology and effectiveness and quality control are the outcomes expected.

4. The Goal-Free Model

Consumers of the programmes are the major audience of goal-free evaluation and the two phases are: (1) assessment of the needs of the consumers which give the criteria for the evaluation and (2) identification of programme performance. Consensus is assumed on the programme performance and needs related criteria. Methodologically the control of bias is stressed in the model. The evaluator is uninformed about the programme when he or she decides on the procedures for assessing how the programme is performing and what are its effects. In goal-free evaluation both intended and unintended effects, i.e. all effects of the programme, are identified (Scriven, 1969; Salasin, 1974). Consumer choice and social utility are expected as outcomes of this evaluation. Scriven has been the major promoter of goal-free evaluation (Guba & Lincoln, 1982a; House, 1978;1980).

5. The Art Criticism Model

This model was developed by Eisner whose field of action has also been Art Education. Eisner (1979; 1985) moved the pattern of art critique to the domain of educational evaluation and because of its origin, this model is considered to have been developed outside the scientific paradigm. The fine arts and art criticism are the origins of the Art Criticism Model. The creation of a piece of art (poem, film, sculpture) presumes qualitative inquiry, 'artists inquire in a qualitative mode', and the critics 'inquire into the work of artists' (Eisner, 1979, pp 190-191). The two elements, artistic work and its critique have given the starting point to Eisner in the development of evaluation.

There are two important concepts in Eisner's model: connoisseurship and criticism. 'Connoisseurship is the art of appreciation, criticism is the art of disclosure' (Eisner, 1979, p 193). Connoisseurship requires the ability to perceive knowledgeably in the evaluation situation. A connoisseur (in this instance the evaluator) has an extensive knowledge base in his or her possession concerning the subject matter. Based on the intellectual and experiential knowledge a critic is contrasting and comparing and this phase of the connoisseurship is a private act. Though the model is based on artistic approaches it requires also theoretical elements to make distinction between the significant and the trivial. To Eisner, a theory 'provides some of the windows through which intelligence can look out into the world' (1985, p 92). But connoisseurship presumes understanding and knowledge about the history and philosophy as well, as they relate to the subject of the evaluation.

Connoisseurship provides material to criticism which is a public act by its nature. Criticism is not negative, it aims at the illumination of the essentials. There are three aspects of criticism: descriptive, interpretive and evaluative aspects. In description, a critic is using expressive language (factual description is not enough) to capture 'the subtle particulars' or the essence in the object of evaluation and patterns in social processes and structures. The interpretive aspect includes the use of theoretical ideas. The evaluative aspect means making a judgment based on the criteria held by the critic and grounded in the philosophy and history of the subject matter. The criticism is expected to expand understanding and heighten awareness of given events among connoisseurs and consumers.

The art criticism category in the taxonomy is summarized according to House (1978;1980): art criticism considers connoisseurs and consumers as the audience; it assumes consensus on the standards upon which the critic does the judgment; critical review is the methodological focus and the expected outcome is the heightened awareness amongst consumers and via this, improved standards.

6. The Professional Review or Accreditation Model

The audience of the professional review evaluation are the consumers or the group of practitioners concerned. This model requires agreement on the evaluation criteria and on the procedures employed in the assessment. Methodologically the model relies on the judgment of a review panel. The Professional Review Model with its procedures and especially with its minor research input seems to be very different when compared with the other models presented in this section. This model is based on the assumption that fellow professionals or professional peers are best assessors of the quality of a programme. The judgment of the professional peers will form the outcome of the evaluation. No individuals have been mentioned as promoters of this model (House, 1978, 1980: Popham, 1975).

7. The Quasi-Legal Model

This model imitates a court. The audience of the evaluation is the jury. Consensus is required about the judges, i.e. about the members of the jury and about the overall procedures of the 'court'. Quasi-legal procedures are employed as a methodology. Issues for this type of evaluation which often is adversarial may emerge from various areas of social life. The jury is collecting evidence about the issues by employing various methods, for example, by conducting investigations, interviewing, conducting surveys and hearing witnesses. The jury will weigh the evidence gathered and formulate the final judgment about the programme, which constitutes the outcome (House 1978; 1980). Among the promoters of the Quasi-Legal Model is Owens (1973).

8. The Transaction-Case Study Model

With the Case Study Model the evaluator aims at illuminating the processes of a given programme by exploring how the actors of the programme view the programme

reality. This model has several advocates and therefore several applications. According to Stake, a case can be any system with defined boundaries, for instance, it can be an individual, a population, an institution, or a programme. Case study is an appropriate methodology when the aim of the inquiry is humanistic understanding and/or extension of experience. In justifying this methodology, which is able to capture the particular, Stake has used the term 'naturalistic generalization'. The term implies that the inquiry is at the same time intuitive and empirical (Stake, 1978). A case study approach treats the programme as a whole without reducing it to few key variables. Transactions in this model are those between the actors of the programme, though the evaluator exhibits sensitive qualities as well (Stake, 1976). One of the special features of case studies may be that they are 'epistemologically in harmony with the reader's experience and thus to that person a natural basis for generalization' (Stake, 1978, p 5).

Patton (1987) has invented the notion of creative evaluation and incorporated the ideas of responsiveness as a characteristic of programme evaluation and overall flexibility to creativity. The use of these two parameters (i.e. responsiveness and flexibility) in Patton's theory is exemplified by the following characterizations: evaluation approach is shaped by those people with whom the evaluator is working; evaluation demonstrates sensitivity and recognition of the constraints of different situations; the evaluator aims at observing his or her own action, and will be aware of the impact of his or her own presumptions; multiple methods will be used and finally, the four evaluation research standards are followed. Guba and Lincoln (1982a) also believe in responsive evaluation and they argued that, in principle, all other evaluation models could be applied within a case study approach - depending on the concerns and issues of the audiences. These authors have also given great significance to naturalistic methodologies which this type of evaluation almost exclusively employs.

Illuminative evaluation proposed by Parlett and Hamilton (1976) for innovative programmes, has been considered as one instance of the case study model. According to these authors, illuminative evaluation is a general research strategy which has assumed the anthropological paradigm. In this model, the evaluator goes through three phases, first by observing and becoming illuminated, then applying further systematic inquiry and finally, attempting to offer explanation. Or as Parlett and Hamilton (1976,

p 141) have described their model, this strategy is an 'intensive study of the program as a whole: its rationale and evolution, its operations, achievements, and difficulties'.

The case study category in the taxonomy is summarized according to House (1978; 1980) as follows: evaluation is addressed both to the practitioners and to the clients; negotiations form the bases of consensus, evaluation employs naturalistic methodologies and evaluation aims at understanding.

In summary, the picture which seems to emerge from the literature on programme evaluation suggests the following characteristics. The ultimate goal of evaluation is the betterment of the lot of human beings which brings it into connection with fundamental issues in society. A major purpose of evaluation is to demonstrate the worth and merit of a given programme. That feature contributes to a special atmosphere surrounding evaluation; typical to this atmosphere are rational expectations but also some feelings of threat. Evaluation strategies can be placed on a continuum from controlled experiment and quantitative methods to naturalistic investigation employing qualitative approaches. Behind the former is the research tradition of natural sciences and the latter draws its ideas from the anthropological research tradition. Experimental design in programme evaluation seems to uncover fewer essential characteristics of evaluation than naturalistic evaluation. With few exceptions, programme evaluation has a research component within its strategy. A broad viewpoint to evaluation object, along with the multiplicity of sources of information and methods of data collection, will strengthen programme evaluation. Within programme evaluation, epistemological discourse is visible which can be expected due to the fact that programme evaluation broadly speaking has been born within social sciences.

In principle, programme evaluation is borrowing its methods from social sciences and it is the context of evaluation and its linkage with policy and decision-making which gives a special flavour to programme evaluation. In essence, evaluation builds on nuanced questions and on needs emerging from a particular decision-making situation. There is the need to find a balance between scientific rigour and political relevance in programme evaluation. The views of evaluators may be rigid or flexible in regard to the basic methodological issues. There is identifiable in the literature a liberal approach

to evaluation which seems to support theoretical and methodological pluralism in this area.

Programme evaluation is situation specific; it is responsive to the information needs of its audience and there is the intention to foster the use of evaluation and application of the recommendations. Evaluation may satisfy the needs for information residing in the general public, in other words, instead of closely involved actors only, the audience of an evaluation may be quite large. Conceptualization by means of models aims at demonstrating how programme evaluation might be implemented but the intention is not that any of the models should be followed literally. An evaluator may come from within or from without in regard to a programme, but it is essential that any evaluator knows the concerns of those involved in the programme.

This study was conducted within the broad concept of programme evaluation research. In this programme evaluation, the ultimate goal was the betterment of the lot of human beings. Thus, the study had a linkage with decision-making. This investigation followed the naturalistic paradigm and it employed qualitative methodologies and utilized a multiplicity of sources of information and methods of data collection. Theoretical and methodological pluralism were a part of the research strategy.

2.4.2.5. The use of programme evaluation

In the very early stages of the development of evaluation research, Scriven (1969, first published 1967) stressed the importance of recognizing the different roles of evaluation. For instance, formative and summative evaluation were the roles mentioned by Scriven whose examples were all from the area of curriculum development. While there seems to be a connection between Scriven's statement about the varied roles of evaluation and the use of evaluation presented by Patton (below), the range of utilization presently is much wider than that suggested by Scriven.

The categorization presented here was originally developed by The Evaluation Research Society Standards Committee and has been summarized by Patton (1982). The following six categories show how programme evaluation can be employed.

1. Evaluation can be employed prior to the actual programme to give guidance for planning and programming and even to show the feasibility of the execution of a given programme.
2. Evaluation can be put into work to assist in the selection of evaluation approaches and methodologies for the final evaluation.
3. Formative evaluation would elicit information for the modification of the programme while the programme itself is still in progress.
4. Summative evaluation would inform particularly decision-makers about the results, outcomes or effects of the programmes.
5. Programme monitoring has been considered to be a separate category and it means the constant reviewing of the programme operations.
6. Evaluation of evaluation, or meta-evaluation as it is also called, means that the evaluative and critical mind of the evaluators would be turned towards their own evaluation practice.

The use of programme evaluation in nursing is here presented under two categories, namely programme evaluation in education and programme evaluation in human service programmes. Those areas were earlier identified as two major roots of ideas in programme evaluation. The projects exemplifying the use of programme evaluation have been deliberately chosen by employing flexible criteria. This has been done for two reasons: firstly, to be able to give a comprehensive picture from a programme evaluation perspective, and secondly, there are no definite boundaries which would automatically justify the inclusion or exclusion of evaluation projects.

Programme evaluation in nursing education Evaluation issues in regular nursing education and continuing education seem to have been addressed separately in the literature. Here evaluation is discussed as a totality. The development which has taken place in the educational field suggests that general philosophy and methods of programme evaluation have been employed in tailoring evaluation models for specific purposes (Alexander, 1983; Gosnell, 1984; Holzemer et al., 1980; McMillan, 1987; Poteet & Pollok, 1986; Smillie, et al., 1984; Smith, et al., 1983; Sohn, 1987; Tiessen,

1987; Waltz & McGurn, 1983). Though there are differences between the models there are many commonalities as well. The models address impact, operation, and product of a programme, or structure, process and outcome of a given programme. The direction seems to be towards comprehensive approaches which take into consideration many, if not all, facets of educational programmes. In other words, evaluation is focused systematically and in an integrated manner on: (1) philosophical and theoretical frameworks underpinning educational programmes; (2) policies, organization, administration and resources; (3) faculty, i.e. teaching, scholarship and service; (4) curriculum; (5) teaching-learning process; and (6) students, their knowledge, attitudes and practice. Programme evaluation models identify the source of information (people and written documents) and data collection methods (e.g. interview, observation, survey, review of documents or audits).

A model may be explicitly linked with decision-making (e.g. Poteet & Pollok, 1986; Waltz & McGurn, 1983) and has a timeframe. Identification of the audience of an evaluation and reporting the evaluation results to this audience, with the aim of promoting the implementation of the recommendations, are matters included in the programme evaluation models. By definition, an evaluation is tailored for a particular programme, therefore, its outcomes are the concern of its particular audience and probably reported only to that. For instance, Smith with her associates (1983) dealt with a continuing education programme in oncology nursing and Waltz and McGurn (1983) described a programme evaluation developed for an academic department. In addition to the comprehensive evaluation models, there are evaluation strategies which focus on one aspect of an educational programme; examples are curriculum evaluation (Chambers, 1988), faculty evaluation (Bell et al., 1984), measuring student success (Jako, 1980), longitudinal study in support of the development of a novel programme (Fitzpatrick et al., 1986) and follow-up studies of graduates (Bergman et al., 1982; Bircumshaw & Chapman, 1988; Hardy et al., 1984). As the evaluation models are tailored for special purposes, so are the instruments employed in evaluation, or generally available tests are used. An attempt has also been made to develop a formative and summative evaluation package for general use in post-basic education (Layton et al., 1981).

Gosnell's (1984) work exemplifies the intention to develop a classification system for continuing nursing education. Her four-stage schematic model includes: (1) evaluation

of perceptions, opinions and attitudes of participants; (2) evaluation of measurable affective, cognitive and psychomotor outcomes of continuing education; (3) evaluation of behavioural performance of participants; and (4) evaluation of outcomes and results in terms of efficiency, effectiveness, adequacy and appropriateness and in terms of improved nursing care. Tiessen (1987) as well, has offered a model which attempts to create order into continuing education. Her systems theory model integrates orientation, inservice education and continuing education into a comprehensive whole which has as its ultimate goal improved patient care.

It is a pattern in continuing education (in a narrower sense than in regular education) that the purpose of evaluation is to find out if the objectives of the programme were reached, how the programme might be improved, and if the knowledge and skills have been used and with what results. This last purpose of continuing education requires some clinical measures (e.g. Harrison & Novak, 1988; Smith et al., 1983). A method of programme evaluation frequently employed in continuing education is what is termed one group pretest - posttest design (Faulk, 1984; Sheahan, 1981; Wilson, 1984) which is often methodologically questionable, and also an example of partial utility.

Programme evaluation in human service Discussion about the models and general approaches employed in evaluation, can be found in the literature. This discussion, in a sense, represents the methodological discourse in programme evaluation. In that discussion, several themes have appeared. True participation of consumers of service programmes in the evaluation, careful identification of evaluation audiences and application of analytical procedures have been suggested (Munro, 1983; Rovers, 1986). Waltz and Bond (1985) have considered accountability, relevance, timeliness and communication as being keys to successful evaluation. Shields (1974) has constructed an evaluation model which is focussing on various kinds of resources assigned to the programme, its organizational framework, its operations and outcomes; whereas Long and Wilkinson (1984) have proposed Suchman's classic evaluative approach for nursing.

The evaluation of human service programmes has been focussed on various topics such as maternal and child health services (Mast, 1978), nurse-managed health centre

(Woog et al., 1981), head trauma rehabilitation (Do et al., 1988), cardiac rehabilitation (Toyama et al., 1988), pain management team (Ferrell et al., 1988), nursing support in disabling chest disease (Heslop & Bagnall, 1988) and nursing aides scheme (Betts, 1987). The actual human service programme evaluation does not indicate as clearly as the educational evaluation that coherent evaluation models would have been developed. Evaluation rather describes the development (Reuter, 1988) or use of various methods in data collection for evaluation. Such methods are evaluation tool for assessing functional and cognitive capacities of a patient (Do et al., 1988), review of patient records (Ferrell et al., 1988; Geiser et al., 1988), interviews (Betts, 1987; Woog et al., 1981), phone survey (Walsh, 1987), questionnaires (Englehardt & Evans, 1988), site visits by external assessors (Woog et al., 1981), staff observation and continuous monitoring (Mast, 1978; Toyama et al., 1988) and experimental design with multiple methods (Heslop & Bagnall, 1988).

In conclusion, evaluation models and strategies utilized in education seem to provide information with some, often extensive, generalizability, whereas the outcome of evaluation is context specific and probably not reported at all. On the other hand, the literature indicates that programme evaluation has also been employed in an inconsiderate manner (e.g. one group pretest-posttest design). Examples of human service programmes suggest that programme evaluation has been employed to find out whether a newly established programme is reaching its goal or whether it is developing in the planned direction. In evaluation, various methods have been utilized, often also anecdotal evidence. On the whole, human service programme evaluation has been situation specific to such extent that (on the level of an evaluation model) it elicits little generalizable information. However, it fulfils the basic function of programme evaluation. There is a need to employ programme evaluation for particular purposes, not necessarily of interest to those not involved in the programme. But there seems also to be a potential for programme evaluation which could contribute to wider understanding of nursing and to nursing knowledge.

3. Method

3.1. Introduction

In this chapter, the evaluation design is presented and the two study settings and the sources and nature of the data are discussed. When the theoretical thinking and methodological underpinnings of this investigation were presented in the first and second chapter, the object of this evaluation was perceived to form two levels, i.e., those of the overall Nursing Programme, which is approached as an organization, and nursing as actualized, which is approached as clinical practice. Similarly, the study setting is conceptualized as having the following two stages: (1) the overall Nursing Programme, in other words, the administrative, educational and other supportive events on a national level and (2) nursing in the Participating Centres, in other words, the implementation of the Nursing Programme on the local level. Data gathering instruments and procedures, as well as the nature of the data are described as part of the two study settings. In the next chapter, which includes the analysis and presentation of the data, the same two levels in analysis are employed.

3.2. The evaluation design for this study

The particular evaluation strategy outlined in this section presents a research design which, 'deals primarily with aims, uses, purposes, intentions and plans within the practical constraints of location, time, money and availability of staff' (Hakim, 1987, p 1). The design for this study is constructed of three interrelated elements. First, the assumptions underlying this investigation, and stated earlier in the introductory chapter, are repeated. They represent 'aims' and 'intentions' in the definition of a design. Second, choices of great importance are outlined. These choices are mainly related to 'purposes' in the definition of a design. Third, more detailed description of this particular programme evaluation is given. This element has linkage with 'uses' and 'plans' in the definition of a design.

It is assumed that the object of this evaluation, the Nursing Programme, was not an effort in isolation but was part of a much broader historical movement in the profession of nursing. Therefore, it is also assumed, that it is possible to draw some recommendations out of this investigation for future nursing policies. These assumptions together with the research questions have led to the following three significant choices.

1. A broad professional background is provided which is presumed to characterize the historical movement in the profession of nursing. This part of the text is located in the second chapter.
2. A conceptual framework is constructed. Epistemological discussion provides the rationale for the framework. The conceptual framework has to have the power to prevent theoretical isolation and to provide the necessary distance for the investigator from the object of the evaluation. The conceptual framework as such becomes an ingredient of the overall design of this inquiry.
3. The third element of the strategy is a detailed evaluation design constructed for the present study.

When the various models in the evaluation taxonomy were introduced as a part of the literature review, they were described with the concepts audience, consensus assumed, methodology and expected outcome. The evaluation design for this study is mainly built around those same concepts.

Audience In formulating the design, the identification of the receivers of the evaluation outcome and the recommendations for the future policy are considered to be interrelated. There were many interested parties in the Nursing Programme but only the theoretical and practical interest of the investigator has shaped the evaluation. The evaluation theory does not dictate to whom the evaluation should be directed, and therefore, it is possible to select a group of people who would have an interest in matters arising from this investigation. This group can be called an audience of the evaluation. In theory, there are three options from which to choose the audience for this evaluation, and they are: patients and clients, nurses and the governmental authorities and other organizations represented in the Consultative Committee through

individual membership. Patients' and clients' views are significant in this study but there seems to be no way this evaluation could be directed to their future decision-making. Similarly, to consider the members of the Consultative Committee as an audience in terms of nursing and its advancement could not be justified either. Certainly, all the members and in some sense also their organizations had a stake or a share in the Programme, but to suggest policy directions for such a varied audience is considered unreasonable. Therefore, nurses are considered to be the audience, and it is at their future policy-making that this evaluation is directed.

Consensus As has been noted earlier, this programme evaluation does not have active interested parties linked to it as is very often the case in programme evaluation. Therefore, consensus (for instance, on goals against which to measure the outcomes or on procedures to be employed in the evaluation) is not necessary. However, a shared understanding about the significance of the two assumptions is required. In other words, this investigation rests on the presumption that the Nursing Programme was a part of the general professional development in nursing, and therefore the evaluation may form a basis for future policies.

Methodology In this evaluation, theory has been given an important function. A conceptual framework has been constructed for this evaluation. The conceptual framework had to have the power to capture the complexity of the object of evaluation. As Meleis (1985, p 92) has stated 'theory provides the mechanism from which we can organize our observations, focus our inquiry, and communicate our findings'. Theory has a double function. It is focusing the investigation, and it is refocusing the findings back to the larger body of knowledge. It is through the interplay between the conceptual framework and the evaluation that the future projections will be formulated, and policy recommendations will be suggested.

This view about the role of a theory is related to the discussion about the generalizability of the findings. As pointed out by Diers (1979), the conventional lack of theoretical framework in programme evaluation has explained the singularity of the results. That is not, however, the issue in this study. Because evaluation is situation specific, and this investigation is employing mainly qualitative approaches, the question about generalization in the traditional sense is not relevant. Stake has

remarked about case studies that 'they may be epistemologically in harmony with the reader's experience and thus to that person a natural basis for generalization' (1978, p 5). It is Stake's notion of generalization which has been assumed to contribute to the utility of the findings.

It is assumed that the diverse actors in the Nursing Programme represented plurality of values and perspectives. The structure of the Programme was built on the assumption that various actors and organizations involved would take the outcomes and work on them. Therefore a balanced analysis is required whereby the views of nurses who were the driving force behind the Nursing Programme, and the views of those whose main interests lay in other matters in the society, are equally approached and explored in their particular contexts. The conceptual framework of the organizational analysis is directing the evaluation to use different perspectives and to provide different types of interpretations.

In this study, the role of the evaluator will simply be the role of the investigator and previous familiarity with the Nursing Programme is acknowledged. It is assumed that the familiarity and the experience with the Nursing Programme enables the approach called connoisseurship in the art criticism model, i.e., an ability to recognize significance.

Outcomes Evaluation is shaped by the particular circumstances which surrounded it. It is inherent in programme evaluation that it will take place in a turbulent atmosphere because evaluation always entails some kind of judgment, and often concerns matters on a very personal level though the main focus of this study are collectivities. No acute turbulence is expected, however, the research design aims at seeking perspective and balance, and in the analysis the attempt is made to discuss the findings against a broader background. Furthermore, the research strategy aims at increasing the understanding of the events which together made the Nursing Programme. The understanding will be built by several means. The conceptual framework will serve that purpose. Comparisons will be made within the Nursing Programme, and between the Programme and the outside world. By identifying significant qualities, the model attempts to raise self-consciousness and general awareness in the nursing community.

The role of recommendations in this investigation is similar to recommendations in research generally.

3.3. Evaluation of the overall Nursing Programme

3.3.1. Definition of the boundaries and identification of the documents

Examining the Nursing Programme as a totality is necessary for defining the boundaries of the evaluation. The time frame, the organization, and events which took place in the name of the Nursing Research and Development Programme are the parameters of the boundary setting. The natural history of the Programme is included in the background of the study. This history shows the specific international links of the present study and in principle, this investigation is focused on a national application of an international project. That body of the text provided the historiographical context for the inquiry, and it located the study in its theoretical context. To describe the overall WHO Medium-Term Programme in Nursing/Midwifery, WHO documents have been employed.

Events in the 1970s, and to a certain extent at the beginning of the 1980s, formed the context of the Nursing Programme. The context refers here to the picture of the time or the nature of the world into which the Nursing Programme was instituted. The descriptors of the context were selected from those matters which seemingly had an impact on nursing or which were thought to be issues in nursing, and were documented by the nursing community itself. Contemporary material from the archive of The Foundation of Nursing Education, three nursing journals, and some governmental documents were used to chronicle the context. This part of the text locates the evaluation in its historical context.

The actual evaluation has covered the Nursing Programme from the time when the focussed planning of the project began to the year following the Programme. The focused evaluation then covers the years 1977 - 1984. The evaluation was extended to the year 1984 because it was felt necessary to follow the handling of the

recommendations which were formulated at the completion of the Programme. Those recommendations were addressed to the governmental authorities. The written sources within those boundaries have been utilized. The programme documents are located in the archive of the Nursing Programme which is situated in the Nursing Research Institute. In addition to the archival material, four key members of the steering system were interviewed in 1990 to receive their views about the Programme. To follow the handling of the recommendations, interviews were conducted in 1989 with two high level administrative officers, and the documents located in two governmental archives, those of the Ministry of Social Affairs and Health and the National Board of Health, were consulted.

3.3.2. Description of the administrative documents

The archival material upon which this investigation is based, is reasonably well organized and easily accessible. In this material, Minutes of the pre-planning group, the Coordinating Committee and its task forces, Consultative Committee, Project Group, and seven memoranda are explored by using content analysis. Other documents are used as sources of factual information. The following table summarizes the nature and amount of the administrative documents included in the study.

Type of the document	Purpose	Audience	Who wrote the document	How many documents
Pre-planning and task force documents	Beginning to conceptualize and shape the impending Programme	Pre-planning group and task forces themselves	An ordinary member of the group/task force (2), later the Programme Manager; or secretary of the task force(1)	15
Official planning documents	To establish the official status of the Programme and get it started	Governmental authorities, potential participants; later, the Consultative Committee and the nurse actors	A member of the Coordinating Committee, later the Programme Manager	3
Minutes of the Coordinating Committee	Administrative	The members of the Coordinating Committee	The secretary of the Coordinating Committee	36
Minutes of the Consultative Committee	Administrative	The members of the Consultative Committee	The secretary of the Consultative Committee	16
Minutes of the Project Group	Administrative	The members of the Project Group	The Programme Manager	49
Annual plans	Administrative; served as funding proposals	The members of the Consultative Committee and the Project Group	The Programme Manager	5
Annual reports	Administrative and informative	The members of the Consultative Committee and the Project Group, Type I, II, and III Participating Centres	The Programme Manager	7
Memoranda and papers	To provide background information for the agenda items; to inform various audiences	Members of the Consultative Committee and the Project Group; various interested audiences	The Programme Manager	38
Letters	Information exchange	Participating Centres mainly	The Programme Manager	45

Table 3.1. Summary table of the documents

The archive of the Nursing Programme - which included the documents produced particularly for that Programme - did not contain material for describing the context of the Programme. Therefore another archival source had to be located. Necessary data to gain insight into the 1970s was located in The Foundation for Nursing Education,

which from an early stage supported the idea of the Nursing Programme and later became a corporate member of the Consultative Committee of the project. Through a special section in its Annual Accounts from the years 1970 - 1980 it provided the required information (Sairaanhoidajien koulutussäätiön toimintakertomukset 1970 - 1980). Comparison of the data obtained from this archive with the picture given by the national nursing press, seemed to suggest that these Accounts accurately reflected the contemporary debate in the nursing profession. There were additional reasons for the use of the archival material from the Foundation for Nursing Education: 1) the Foundation had during those years a coordinating role in nursing, and it represented a broad professional interest; 2) the Annual Accounts of the Foundation were written with the future historians in mind, and therefore they documented historical development, identified problems, and subjects of discussion in the profession of nursing; 3) in addition, the Accounts were annually approved by a representative body of professionals.

3.4. Evaluation of nursing in the Participating Centres

3.4.1. Identification of the Participating Centres and the datasets from the Centres

At the beginning of this section, the second study setting mentioned was nursing in the Participating Centres. Participating Centres were those schools (N=2), primary health care centres (N=10), university central hospitals (N=5), central hospitals (N=4) and mental hospitals (N=2) which - by the procedure of self selection - had become official and active participants on the national level in the WHO Medium-Term Programme in Nursing/Midwifery. The data originating from those study settings comprised the four following datasets which were created at the end of 1983 and/or at the beginning of 1984.

1. Accounts written by the Contact Persons (N=17) were generated by using account writing as a method. These are five or six pages long texts which contain the personal views of Contact Persons about the essential matters in the

Nursing Programme at its completion. Content analysis was used in the analysis of the accounts.

2. Nursing Care Plans (N=99) were like clinical records with the exception that they were prepared as tests in simulated situations. These plans were expected to demonstrate how the nursing process was used in actual practice and were prepared in the Participating Centres in natural environments but by employing a written description of patients and clients. These simulated clinical records have been analysed by using five preset criteria.
3. A survey method was employed to obtain the views of patients and clients (N = 301) in regard to their experience of being recipients of nursing care. These computerized data were analysed by using tables of percent distributions.
4. The final reports written by nurses (N = 41) summarize the work done in clinical environments and in the schools in the course of the Nursing Programme. This material also includes views expressed by nurses about their participation in the project. The majority of the reports were published after editing but in this investigation, unpublished and unedited versions were used. The unedited final reports were numbered for referencing. The method used in exploring these sources was content analysis.

3.4.2. Description of the instruments and procedures

In this section, the instruments used in the data collection are described. Their particular role in the study is also highlighted. After the descriptions, the procedures used both in data collection and in data handling will be clarified.

Guidelines for writing an account about the results and significance of the Nursing Programme This instrument was a two-page text targetted at the designated Contact Persons in the Participating Centres. It included a statement of the purpose and suggestions for the actual production of the account. Discussions with the personnel were considered desirable. Respondents were warned about exaggerations, and they were asked to be accurate with the dates if time factors were to be part of their answer.

The Contact Persons were asked to give their expert opinion, to write in the first person, and to sign the account. The following themes and sub-headings were given for the account: the practice of nursing, research and development in nursing, nursing education, nursing administration (including leadership), nursing in the future and other views which they considered important to document. It was indicated in the instrument that the accounts will be handled anonymously.

Nursing Care Plan This was a collection of the instruments which were employed to test the application of knowledge in simulated working situations. The focus of this test was the nursing process as a clinical method. Guidelines for preparing a nursing care plan were contained in a two-page form. It stated the purpose of the procedure which was to demonstrate how systematic nursing was implemented in actual practice. It included the requirement that the test nursing care plan should be prepared in the same manner in which planning takes place in everyday practice (e.g. as a product of a group or an individual, or within time limits). These guidelines also described briefly the principle content of the columns in the nursing care plan which was an A3-size form with six columns into which the following information was supposed to be recorded: 1) observations about the patient or the client which led to the identification of a need, 2) identified needs for nursing, 3) stated objectives, 4) plan for nursing, 5) implementation of the plan and 6) evaluation of the outcomes. The form can be considered to be a pencil-and-paper test with clinical content. Some identification information was also recorded about those preparing the plan as well as about the time required for its completion. As was earlier mentioned, this test took place in a simulated situation. The use of the nursing process was demonstrated by employing written descriptions of patients and clients and there were six different types of written portraits of the recipients of nursing which originated from real life situations. Through some alterations the identification of the individuals was prevented.

Questionnaire for patients and clients There were two slightly different forms, one for the clients in health centres and the other one for the patients in the institutions. Only the wording in some technical matters was different, and it was in accordance with the language used in health care. This instrument was an eight-page questionnaire with closed and open-ended questions. The form was planned to cover the nursing process from the perspective of the recipient of care. In the pilot run of the questionnaire, 15

patients or clients filled out the form outside the study setting and corrections indicated by the pilot were made. (See Appendix One, p 251)

The data collection instruments, 1) guidelines for the accounts, 2) forms for the nursing care plan and 3) patient and client questionnaires were sent with detailed additional instructions to the Contact Persons. It had been agreed and clarified in advance that these actors would coordinate the data collection locally and the same kind of procedure was applied as part of the base line study. At this stage the Programme Manager did not visit the sites of data collection and all the forms were returned to the Nursing Research Institute.

Contact Persons were easy to identify and no sampling was undertaken. Nursing care plans were prepared in all centres actively participating in the Nursing Programme. On a given day and during the morning shift, the Contact Person selected those who would produce the plan. A special sampling frame was established for the identification of the consumers of nursing care.

Only units active in the Nursing Programme formed the setting (one of them was a Type I Centre), and sampling can be called purposive. The sampling frame was the nursing clientele in the Participating Centres which was assumed to have been exposed to the kind of practice suggested by the Programme. The additional general criterion for inclusion in the sample was that the person was able to fill in the questionnaire (for a child the parents filled in the form). For long-term care facilities a slightly different instruction was given, because the inclusion of their patients in the study was considered important. In those institutions it was acceptable that some of the relatives would assist the patient. The first three patients discharged from the institutions and the first three clients attending the health centres received the questionnaire from a stated day onwards. The questionnaires were given to the recipients of nursing care by a nurse, and the respondents returned the completed questionnaires to the unit in closed envelopes provided with the questionnaires. In preparing data for analysis, forms where the nursing content was nonexistent (in conventional terms, information about the dependent variable was nonexistent), were excluded from the study.

Final reports There were no forms comparable with those mentioned earlier in this section to guide the writing. Instead a conventional structure of a research report and of a development project were provided. The narrative and sometimes extensive outcome documents were analysed by employing content analysis. The procedure was slightly different than in the case of the administrative documents and coding categories were marked on the documents. Therefore, original reports were consulted throughout the analysis.

3.5. Procedures in content analysis

Procedures employed in content analysis are important in terms of accuracy. The definition by Holsti (1969, p 14) was followed in this action: 'content analysis is any technique for making inferences by objectively and systematically identifying specified characteristics of messages'. The Nursing Programme exists in the documents it produced for administrative and educational purposes or as final outcomes. Content analysis is a multipurpose approach to documentary research developed particularly for investigations 'in which the content of communication serves as the basis of inference' (Holsti, 1969, p 2).

There are three requirements which have to be taken into consideration when this basic research tool is employed. Objectivity is the first of them and it requires that the research process is guided by explicit rules. Objectivity includes also the prevention of a situation in which the subjective predispositions of the investigator are reflected in the findings instead of the content of the documents. The second requirement is being systematic. This is supposed to guarantee that the hypotheses formulated by the investigator do not dictate the inclusion or exclusion of the evidence but that the process is rule-based. Generality is the third defining characteristic by which the theoretical relevance of the findings is emphasized. Based on the theory employed in a particular investigation, communication content is compared with or related to at least one other attribute, whether it is a sender or receiver of a message or a content of another document. In other words: '... a datum about communication content is meaningless until it is related to at least one other datum' (Holsti, 1969, 5). It is hypothesized that these defining characteristics of the content analysis add to the credibility of this particular study.

There are a number of different stages in the application of this method such as developing the coding categories, selecting the unit of content analysis, and establishing the rules and rationale for the actual coding procedure (Fox, 1986; Guba & Lincoln, 1982). Coding categories for this study were created to reflect the central research questions and the general theoretical perspective of the investigation. In this study, the coding categories were not derived from a single classification principle. Due to the varied nature of the documents, three sets of categories were created to be used for different types of documents and/or to be used in locating a certain type of information. In the analysis of the Annual Accounts mentioned earlier, coding categories emerged from the data. The coding system was considered to be a dynamic entity and to subsume the categories emerging during coding. The final coding categories as three entities are presented here.

1. Evolution of the Nursing Programme from the pre-planning phase to the termination of the Programme was described by the following categories: problems and concerns identified in nursing; positive factors in support of the Programme; content and structure when the Programme began to take shape; the purpose of the Programme; the objectives of the Programme; rationale in implementation; issues which emerged during the Programme; organizational auspices; members of the committees; the nature of the network from top to bottom; resources; everyday operations of the Programme (coordination, decision-making, support services); and collaboration.
2. Products of the Participating Centres were described by the following categories: problems in nursing which became the focus of the sub-programmes; value clarification; conceptual frameworks employed; innovations or new approaches in nursing; the four metaparadigm concepts (man, environment, health and nursing action); patterns of nursing; collaboration; and meaning given by nurses to the Nursing Programme and their participation.
3. The last group of categories was created to assure that any information which was related to the objectives of the Programme could be coded: professional language; nursing administration; informing nursing education and nursing

practice about research results and international development; nursing personnel system; and permanent strategy for nursing development.

The analysis of the documents and reports was qualitative. The unit of the analysis was a theme which might form the main content of a chapter or a larger unit in a document. Other possible recording units, namely, a word or symbol, a character, a sentence or paragraph, or an item, were not considered suitable for this study. There were two reasons for that decision. The main focus of the study, that of overall illumination of the Nursing Programme, required larger information units than e.g. words or symbols. The nature of the documents along with the idea of connoisseurship led to the identification of significant and comprehensive themes. With regard to the rules and rationale, the closeness of the researcher to the data was an important principle. As much information as possible was collected about each category. Coding was based on the manifest content of the documents, i.e., what was seen in writing was guiding the coder. If the text conveyed a special tone or gave reason for an immediate inference, that was documented separately. Therefore, the form employed in recording the content analysis of the documents had two columns, a broad space for recording the information about each category, and a narrow space where the recognizable tone of the writing in the source (if there was any), and possible immediate inferences were recorded. By this procedure the essential information from the documents was extracted to the forms. The final analysis was based on the coded data. The coding procedure of the final reports was technically different. These documents were coded by writing the number of the coding category into the text without removing the information.

The analysis of the data proceeds through three phases. Data, situations, events, and interventions are first described, then an analytical argument is developed based on the conceptual framework and finally the significance of the matter is expressed. This is the way the traditional two components, namely description and judgment, are dealt with in this evaluation. The criteria employed in the analysis on which the statement of significance is based are derived from the major goal of the Nursing Programme.

3.6. Trustworthiness

3.6.1. Introduction

In scientific research, regardless of the school of thought within which the study is conducted, there is one common goal identifiable which is to acquire trustworthy information, and various measures have been developed to assist in reaching that goal. For testing causal hypotheses, experimentation with randomization, manipulation of the independent variable and controlling the intervening variables is a well established research design (Campbell & Stanley, 1966). Scales for measurement, in other words, nominal, ordinal, interval and ratio scales, are specified and statistical tests which are compatible with the levels of measurements are known (e.g. Verhonick & Seaman, 1978). Similarly, validity and reliability of the instruments employed for measurements in quantitative studies are founded on reasonably well established rules (e.g. Polit & Hungler, 1987). In a qualitative study where the design as such does not bring any 'control', or where no 'measurements' are made, quite different rules for acquiring rigor are required. Therefore, the emergence of qualitative methodologies has created a new situation among researchers. The unprecedented orientations in many decisive aspects in qualitative methodology have made it imperative to restate the norms governing the trustworthiness of such investigations. This term will be used in this study to refer to the matters which were earlier dealt with under the titles of objectivity, validity and reliability of the study.

3.6.2. The criteria for trustworthiness

This study is mainly following the naturalistic paradigm, yet, included in it are some elements of non-naturalistic inquiry (e.g. some of the terms used originate from the scientific tradition). The procedures needed to ensure the achievement of rigor in a qualitative investigation depend on the purpose of the inquiry; the techniques used in obtaining the data, the nature of the data, and the methodology employed in the analysis (Sandelowski, 1986). Those four aspects are incorporated into the further discussion about the trustworthiness.

Guba (1981) has contrasted the aspects of trustworthiness within the scientific or rationalistic and naturalistic paradigms and suggested criteria for evaluating the rigor. In so doing he has also translated the terms employed within the rationalistic paradigm into 'naturalistic language'. Discussion here follows Guba's suggestion. The scientific term 'internal validity' means that the result of a measurement accurately reflects outcome of the treatment (e.g. a programme), represents the general truth value, and is replaced by 'credibility' in the naturalistic inquiry. The scientific term 'external validity' which is related to the generalizability of findings, represents the applicability aspect, and is replaced by 'transferability' in the naturalistic inquiry. The scientific term 'reliability' conveys the requirement that the instruments must assure stable results and represents the consistency aspect, replaced by 'dependability' in the naturalistic paradigm. Finally, the rationalistic term 'objectivity' which ensures neutrality of the investigation, is replaced by 'confirmability' in the naturalistic inquiry. The criteria for trustworthiness are then credibility, transferability, dependability and confirmability. To establish trustworthiness in this particular investigation or to meet the four criteria, the following techniques are employed.

To ensure credibility, findings are tested against various sources. Triangulation (Denzin, 1971) is employed by drawing data from a variety of sources and by using multiple research methods and several theoretical perspectives to enable cross-checking of data and interpretations. Structural corroboration, suggested by Eisner as a part of the art criticism, is employed. Structural corroboration refers both to information collection and to its use. This is achieved 'when pieces of evidence validate each other, the story holds up, the pieces fit, it makes sense, the facts are consistent' (Eisner, 1979. p 215). Because survey type data is used in this study as well, internal validity was obtained by inviting a panel of experts to review the forms for content validity to assure that the questions asked adequately covered the area of interest.

To ensure transferability in the sense which is compatible with the assumptions of this study, 'thick description' is provided. Thick description means 'full and dense descriptions that will provide a substantial basis for similarity judgments' (Skrtic, 1985, p 201). Sampling was purposive and not aimed at achieving representativeness. Some aspects of transferability were discussed earlier in this study by using the

traditional term generalization. To ensure dependability, the procedures employed in this investigation are made explicit, and the reader is provided with as much descriptive data as possible so that consistency with interpretation is apparent. Triangulation which was already mentioned as contributing to credibility, is a combination of research practices contributing to confirmability as well. Practicing reflexivity which in this investigation is done by explicating the epistemological assumptions underpinning the study is also ensuring confirmability.

3.6.3. Trustworthiness and the documentary sources

The criteria of credibility and transferability are related to the archival documents and final reports as data sources, therefore, these two datasets are discussed in this connection in terms of trustworthiness.

Archival documents The kinds of documents included in this study, the purpose, the audience, and the producer of the documents have been described and their content made explicit (Table 3.1.). These documents are assessed according to the following three criteria: authenticity of the documents, their representativeness of the events and processes, and their objectivity.

Authenticity What is known about the production of the administrative documents and about the procedure for establishing the Programme archive, has led the investigator to contend that the archival material is genuine. Documents have indisputably originated from the Nursing Programme. They have been created intentionally for administrative or educational purposes. They are not personal documents but meant to be delivered to some wider audience though in some instances the writer's personal style has been recognizable.

Representativeness The archive accommodates all the documents except the minutes of one meeting of a task force. All minutes were approved by some audience or they were brought to the attention of some group. There were some corrections recorded. There is evidence to suggest that what appeared in the documents did reflect the

events. The minutes mainly recorded decisions made, and only to a certain extent were the views presented in the discussion preceding the decisions documented. This is a clear weakness in the documents. Some of the planning groups, however, produced minutes in which the content of the text can be said to be lively. It is evident that the minutes may not include all the details which would have been of interest to the investigator, and which for example, an observer in the situation would have recognized. Different kinds of accounts, plans and memoranda were almost regularly criticized by some or several groups before the final version was agreed on. As regards both types of documents (minutes and memoranda), there may have been political or other reasons which had an impact on the content of the final document. This programme evaluation is based on the written evidence as it appears with the conceptual framework imposed on the documents as they are. The documents seem to justify the analytical technique employed: based on the goal and objectives of the Nursing Programme and the roles assumed by the different working parties and committees, it is possible to identify - not only what has been done and mentioned - but also what does not appear in the documents though theoretically the appearance could be expected. Several series of documents are linked together or compared in the analysis.

Objectivity This was explored by the investigator to assess if there were systematic errors or distortions which would have resulted in an incorrect picture which did not portray the Nursing Programme. The fact that there were various audiences for the documents, different procedures for production, and several authors, can be seen to be a confirming or validating factor. The absence of some actors who would have had the right to participate, and the impact of this on decisions can be theoretically acknowledged (this would be mortality in an experiment). Yet, it has not been seen to be a weakness but a finding. The honesty of the documents is not questioned. Documents are unreactive, and content analysis of the documents is an unobtrusive measure (Guba and Lincoln, 1982a; Holsti, 1969). These are some of the strenghts of documentary analysis. Guba and Lincoln have revealed documents to be a rich natural source of information, and an objective way to understanding. These authors have perceived documents to be 'repositories of well-grounded data on the events or situations under investigation' (Guba & Lincoln, 1982a, p 232).

Final reports There are several aspects to be considered in regard to the final reports written by nurses. Partly, the reason for writing was to report back on the investments of the institutions (i.e. schools, health centres and hospitals). But more importantly, the reports were compilations of quite exceptional projects in nursing. This was the first time in history that such an extensive effort to advance nursing had been made, and the art of writing on clinical experience was just emerging. The reports informed about the work done, and they were written for publication. Guba and Lincoln (1982a) discussing the motives behind writing, have remarked that sometimes a tendency may appear to give a more coherent picture of the work processes and the roles of individuals than the actuality would have justified. This motivational issue is also a concern in this study.

There is another aspect about these reports which may be more crucial for knowledge development in nursing. At some early point in the Nursing Programme there were vague ideas about the possibility of encouraging nurses to write without constraints and pre-defined structures about their clinical experience, and through that process to create simultaneously a professional language which was seen a priority area in nursing. However, when the time arrived to write the final reports, a short course in writing was organized and a pre-structured outline for the report was provided. The outline of the report was slightly different for those who reported research studies, and for those who reported development projects. This action of providing guidelines was considered both by the producers and receivers to be a positive and supportive undertaking. It is difficult to estimate whether the imposed structure prevented some original conceptualizations to emerge. These remarks do not, however, justify the conclusion that the investigator is focusing on poor material. This discussion is just acknowledging some facts which are important to explicate. In research terms, the reports are considered to be ordinary written accounts, not more valid or invalid than reports on projects generally.

3.7. Ethical considerations

Propriety is one of the four standards of evaluation research, in other words, the evaluation community believes that the investigator should be able to demonstrate the ethical conduct of the study. That, of course, applies to all research. Making the

process of the investigation explicit, the matter discussed as a part of trustworthiness, contributes on a general level to demonstrating the ethical conduct of the study.

Special ethical considerations are required when respondents are human subjects. Patients and clients, when given the questionnaire, were also informed in writing about the purpose of the study and about the confidentiality of any information they gave. That was a part of the informed consent which stressed the voluntary nature of the participation. Nurses as respondents were approached as professional colleagues who shared the need for information, though their participation was also on a voluntary basis, and confidentiality of the information provided was assured.

There is one ethical aspect which is more related to analysis and presentation of the data than to data collection. Unobtrusive measures (Webb, et al., 1981), as it is understood, require that a balanced analysis is developed at both levels of the study, i.e. at the level of the overall Nursing Programme and at the level of nursing in the Participating Centres. As is the case in policy research generally, analysis is undertaken at the level of the organization and at the level of the individuals perceived as role holders (Hakim, 1987).

3.8. Limitations of the study

The Programme was completed at the end of 1983, and some of its activities continued until the end of 1984. Therefore, it has to be explored to what extent if any, this time lapse might be a limitation. A thorough understanding of Finnish nursing suggests that questions which may be asked in relation to the Nursing Research and Development Programme have not dramatically changed during the four - five year period. Despite the time lapse the comprehensive evaluation can be completed. It may even be that the evaluation will benefit from the distance in time.

The Nursing Programme is perceived as a non-recurrent impulse for the advancement of nursing rather than as an on-going support structure. The whole exercise, i.e. the Programme, was meant to support the overall development and to accelerate the

evolution. Each programme evaluation is situation specific, and in this particular evaluation its relevance is a qualifying criterion (Guba, 1981). The design of this study is therefore built on the idea that understanding the Nursing Programme as a totality is significant.

The programme evaluation as it is conducted, is mainly focussed on the existing documents and evidence available in the archives. Based on that material, a comprehensive picture from different perspectives has been generated. It is assumed that the decision to base the study on unobtrusive measures in core areas of the evaluation requires discussion. Two arguments are presented for that decision. First, it is understood that the Nursing Programme exists in its documents to such an extent that documentary analysis provides an opportunity for programme evaluation. Second, in principle, the collection of the documents is complete which enables the description of the structure and procedures of the Nursing Programme. 'The palest ink is clearer than the best memory' is a Chinese proverb which was used to convey the notion of nonreactive or unobtrusive measures and the value of archives (Webb, et al., 1981, p 196). However, validation of the major findings was done by approaching some former actors in the Programme.

There were two reasons for rejecting the utilization study approach. It seems to be logical that the overall evaluation of the Nursing Programme, such as the present study, precedes the utilization study. Possibly an even more important reason is that utilization research is a separate scientific approach in its own right, and as such it could not become attached to a programme evaluation as an addendum. The few interviews conducted for this study validated the views expressed, for instance by Ciarlo (1981) and Weiss (1981), that approaching the questions about the utilization of research and evaluation is a rather complicated matter. Ciarlo argued that when interviewed, most people would want to tell that they did use the results. Weiss has referred to the complicated measures required in studies of the use of evaluation which is a 'process of understanding, accepting, reorienting, adapting, and applying research results to the world of practice' (Weiss, 1981b, p 17).

When nurses were introduced as the audience for this programme evaluation the arguments were already made for that research decision. But it may be imperative to

consider if by that decision, serious limitation has been created. It may be argued that such constriction of the perspective is separating even more nursing goals and decisions from the mainframe of decision-making, or that it is creating a situation and a world view which have little to do with the reality. The purpose of this study is not to produce that kind of conception. Quite the contrary, it is believed that with the evaluation model constructed for this inquiry, the reality can be explored and it can be brought into the consciousness not only of nurses but their co-workers as well. The decision about the audience was, it is contended, a logical consequence of the intent of the Nursing Programme and of the prime focus of the evaluation itself.

The role of the evaluator is a controversial issue, and it has to be discussed whether the familiarity of the investigator with the Nursing Programme, and more importantly, her previous involvement is a limitation, or whether it could bring strength with it. Based on the presentation of the various evaluation models, the conclusion can be made that the role of the evaluator is shaped by many factors and indeed, in many of those models the evaluator was intimately related with the object of the assessment. Programme evaluation theory does not suggest any constraints which would inhibit reasonable shaping of the role of the evaluator. However, it has been considered to be crucial to explicate the previous involvement, and for example the impact of the evaluator in the production of the programme documents. Likewise, making the research decisions explicit is required. Perceiving the evaluator as an investigator in an evaluation study is supposed to create an optimal distance from the past and role definition is considered to be a positive prerequisite. The familiarity with the Programme, the fact that the investigator is 'illuminated' may constitute a strength for this study as well. This factor is in accordance with the views in the art criticism model where the ability to recognize and appreciate the most salient qualities in the object of evaluation is a necessity. The ability to pinpoint significant features is a strength in evaluation terms and that may be considered as a balancing factor.

In summary, this chapter began with the evaluation design constructed for this study. Study settings and the nature of the data were described. The criteria for assessing the trustworthiness of this study were clarified by using suggestions made within the naturalistic paradigm. Limitations of the study, as well as the ethical considerations were discussed. In the next chapter the detailed data and analysis will be presented.

Epistemological assumptions and criteria for trustworthiness are transferred to the analysis when the research design is implemented.

4. Presentation and analysis of data

4.1. Introduction

This chapter has three major sections. The context of the Nursing Programme is outlined in the first section (4.2.) based on the archival sources of a nursing foundation. In the next section (4.3.), the overall Nursing Programme as an organization is presented and analysed. This second section builds on mainly administrative sources in the archive of the Nursing Programme. In the third section (4.4.) the focus will move to the Participating Centres, and material produced by nurses along with the patient/client questionnaires will be employed. Methodologically, both content analysis and triangulation require comparisons within and among the three sections. Finally, an epilogue is presented to show how the recommendations of the Nursing Programme were received by the government.

4.2. Context of the Nursing Programme

In the present study, the term context is used to refer to the contemporary developments as they related to nursing in Finland. Programme evaluators have linked the context of a particular programme to the evaluation design. As previously noted, Stufflebeam included the context into his model of programme evaluation, and he considered it important that relevant environmental elements be analysed. More precisely, context evaluation was said to identify unmet needs and unused opportunities; to reflect the theoretical and empirical level of knowledge and to provide the rationale for stating objectives; it is also a dynamic baseline of information (Stufflebeam, et al.,1971). Similarly, Stake (1976) considered the description of the setting and the context to be useful to the reader of the evaluation outcomes; and Patton

(1980) has argued that the holistic view required the analysis of the context of the programme, without which the programme could not be understood. To facilitate the understanding of the nature of the Nursing Programme and its organization, the context will be presented.

Archival material of the Foundation for Nursing Education was utilized to establish the perspective through which nursing could be analysed, and to portray the nursing world. These primary data were supported by documents reflecting government health and educational policy, as well as by contemporary discussion in the nursing press. The main themes identified in the Accounts were organized under four headings: 1) the overall health service system and shifts within it; 2) nursing education (which included basic, postbasic and continuing education); 3) the professional perspective which referred to the existence of nursing as a distinct service to people; and 4) nursing organization. Quotations of this section have been extracted from the Annual Accounts of the Foundation for Nursing Education and translated from the original Finnish material.

The overall health service system In the Annual Accounts, both positive and negative factors were observed and documented in regard to the health field generally. Among the general trends and problems identified in the Accounts were the neglect of health care of the adult population, the need to use financial resources in a more appropriate way for community care (outpatient health services), and weaknesses in health planning and coordination. More attention was paid to health education than before; and patients spoke up for their views. The Primary Health Care Act was passed in 1972. Administration and financing of primary health care was prescribed by the law, and the content of the services was determined by the five-year plan approved annually by the government. The same kind of comprehensive planning system was also instituted for the hospital sector.

The implementation of the new law and planning system, though in principle welcome, was not smooth. Quite the contrary: 'The Primary Health Care Act which was coming into force showed what kind of dead end the nursing profession and its education had reached' (1972). This remark referred to the fact that in legislative

alterations the public health nursing tradition was not respected. The traditional comprehensive, family-centered and community-based practice was divided into narrow sectors, for example, according to the age groups or workplaces. The obligations of the public health nurse were so defined that many community nurses lost their formal competency to practice, and they had to go through special educational procedures (Lääkintöhallitus, 1972). The lesson learned in the year 1974 was that 'the public health service is part of the social policy where the goals and interests of the nursing profession are easily displaced by political calculations'. Plans for hospitals and health centres were oversized and not consistent with available resources. 'Health personnel felt that the qualitative and quantitative burden of work was unmaintainable' (1977). Although health education was intensified, prevention and outpatient care were not developing as expected. Topics like health manpower, scope of responsibility, division of labour and delegation of tasks were widely discussed.

In 1980, though many of the problems of the decade were still documented, some new ideas seemed to emerge. There was a tendency to find a way to cope with the available resources. This was done by strengthening the knowledge base of nursing through research and by systematically developing nursing care practices. A growing interest in the human aspects of the health service was apparent. The National Board of Health issued guidelines on research and development in health centres and hospitals (Lääkintöhallitus, 1980). These guidelines made it obligatory for health centres and hospitals to do research and to develop services as required.

Nursing education Nursing education was one of the key issues during the decade concerned. It was dealt with by two committees established by the Ministry of Education for the reorganization of the education of health personnel. Before the recommendations of the first committee had been implemented the next committee began its work. The work of this second committee was, however, only the basis for a third planning phase which - at the beginning of the eighties - took place under the auspices of the National Board of Vocational Education. Continuing education as a general issue in the country was also discussed in the state committee and also this topic seemed to have been one of the key issues of the decade.

At the beginning of the decade, it was believed that academic education was required as a preparation for future nursing and as entry to practice. However, the more nursing education was discussed, the lower was the level of nurse education envisaged, compared with the standards set by the profession itself (i.e. broad general education as a basis of professional education, broad scientific basis as a part of professional education, and nursing as a core of the curriculum). Though it is true that academic programmes were in preparation in several universities, and the first programme commenced in 1979, these programmes left undergraduate nursing education entirely outside academic settings. Nurses had suggested in 1972 that academization should be the future direction in the development of nursing education. Furthermore, new degree programmes were not designed for nurses but for health personnel, nurses included (Ammattikasvatusthallitus, 1984a; 1984b; Opetusministeriö, 1973; 1974; 1977; 1981).

The professional perspective Seen from a purely professional perspective the following observations can be made. 'The right and ability of the nursing profession to participate in health planning, especially in developing nursing service and education for it, were not appreciated' (1970). The theme of the annual conference of nurses in 1973, 'a human being or a cog in the machinery', reflected the general feelings among the nurses. In 1974 nurses experienced 'unbearable pressures', and the archive identified disquiets related to the following problems: low salary, shortage of manpower, the closure of hospital wards and delay in treatment, increase in numbers of untrained caregivers, scope of responsibility and unplanned delegation of tasks, uneven pressure between workplaces, stress due to nature of nursing, day care of children, and safety at work. The situation was driven almost into a crisis. A fear for the future of the nursing profession was documented in 1976.

At the beginning of the decade, reference was made to 'internal weaknesses' which inhibited the optimal use of nursing resources. Three reasons for that situation were given: lack of shared goals, lack of coordination and lack of information. It was suggested that an analysis of the situation and creation of a strategy for nursing might bring some progress. It was stated that nurses needed better education, that the systematic application of existing knowledge into nursing practice should take place and that nursing should be more widely investigated and conceptualized (1970).

Nurses expected more interaction with the health and educational authorities. In reality, it was believed that the nursing profession would obtain more influence. The aspirations of nurses, as a group and as individuals, for more influence were strengthened (1972).

But there was a general uncertainty about the scope of nursing which was traditionally divided into practice, education and administration. Nurses themselves had shaped their future role so that it would take them from direct care towards coordination and management of nursing care. The nurse was perceived as an expert participating in practice, education and administration, and therefore academic education was required. That drew attention to nursing knowledge and its credibility as an academic subject matter.

In the year 1976 nursing was the topic of the technical discussions¹ at the WHO Regional Committee. It was felt that this single fact strengthened the position of nursing and provided 'a substratum' for national development. According to these technical discussions, health promotion and disease prevention provided the future direction for nursing. The 'Health for All' movement starting with the International Conference on Primary Health Care held in Alma Ata in 1978, was noted by nurses as a new international health policy.

The Annual Accounts registered very clearly the similarities in themes and efforts in the international nursing community of which The International Council of Nurses and The Northern Nurses Federation were examples. In 1979 it was reported from the international discussion that there was a need for nurses who were interested in the health of communities and who would be able to function without expensive technology. The nursing literature confirmed the positive and dynamic nursing movement (Altschul, 1979; Auld, 1979; Chapman, 1977; Gortner, 1974; Hall, 1980; Henderson, 1978; McFarlane, 1976a; Schlotfeldt, 1972; Tiffany, 1979).

¹Technical discussions are conducted about topics of general interest in the Region. These topics are not on the agenda for resolutions, however, the discussion or conclusions drawn from it may be documented as happened in 1976 (Technical Discussions, 1976).

Towards the end of the decade the role of research became important. In 1977 it was stated that decision-making about nursing matters (e.g. division of labour, manpower and resources, monitoring and education) required thorough investigation. In 1980 it was believed that research was becoming accepted as a basis of practice, and as complementary to medical research. The need for systematic development in nursing was also recognized, and nurses assumed that they had to meet that challenge. 'The traditional aspiration for constant professional growth in the middle of change and increasing pressure was evident' (1978). One of the inhibiting factors was diagnosed, and that was the outdated administrative pattern: nursing was not represented at the highest decision-making level. A general reform of regulations governing decision-making in health centres and hospitals was in progress. Nurses felt that the clarification of the nature and uniqueness of nursing was necessary. As the content of the new service regulations would determine the future environment where nursing would be practiced, it was vital that in any set of regulations nursing as a distinct part of health care would be made explicit. However, the outcome of the decision-making concerning the reform of regulations by the end of the decade, did not fulfil the expectations of nurses.

Nursing organization One trend of development could be seen in the professional organization of nurses. At the beginning of the period concerned, the organization changed its basic orientation almost exclusively towards bargaining over the interests of nurses. It continued changing its organization by establishing local branches of a trade union and encouraging nurses to use the newly established system. And finally the professional organization decided to found a trade union with other health workers, some of which were professional, some not. Trade unionism had taken the major role in the nursing organization.

In conclusion, two parallel lines of development seemed to emerge. Firstly, nurses were excluded from strategic decision-making in matters of crucial importance to them. The major concerns of nurses which were related to the scope of practice, resources, and education, along with the overall position of nursing, were not solved. The major professional organization of nurses was using those ten strategic years - strategic in terms of changes in education, health service system and its management -

to construct a new machinery for becoming more efficient in bargaining over wages and working conditions of health workers. Secondly, there was a constant interest in important professional matters, and a belief in a better future. Research and development were identified as useful means, and coping with insufficient resources seemed possible. It was evident that discussions about the European Programme for nursing development were already reflected in the last Annual Accounts of the decade. The profession of nursing responded to certain major issues by creating a climate of innovation. The picture given in literature (cf. Ashley, 1976; White, 1978; Stevens, 1984; Meleis, 1985) is very similar; professional aspirations on the one hand and practical reality on the other.

One might expect that the social environment of nursing would have resulted in demoralization because nurses had experienced severe problems. Based on the archives, however, a positive spirit was emerging despite the setbacks and the profession of nursing seemed to be prepared for meeting new challenges. Yet, there was no indication in the documents which would have explained the positive spirit at the end of a difficult decade. The project history of the Nursing Programme offered one possible explanation (Sorvettula, 1984). It considered the previous networking and nationwide explorations of nursing issues as a positive precondition for the developmental activities. A kind of professional awareness was created and based on that, the opportunities opened by the European Programme could be recognized.

4.3. The overall Nursing Programme

4.3.1. Introduction

Various groups with their mandates formed the organization of the Nursing Programme, and the activities of those groups formed a major part of the organizational processes. The written documents generated by those groups constitute the bases of the organizational analysis in this section. All quotations have been

translated from the original Finnish material. The focus of the analysis is rather the organization and the aggregates of people than individual actors of the Programme. An attempt is made to create some order into the organizational processes by distinguishing the phases of the Nursing Programme and the levels of the organization. In table 4.1., a chart of the phases and levels is presented. The phases of the Nursing Programme are outlined as organizers, but they are not units of the analysis, whereas the levels of the organization are analysed by using metaphors introduced by Morgan (1986), and presented earlier as a part of the conceptual framework.

Phases of the Programme	Levels of the organization	Status of the group	Period of the office
Pre-planning phase	Pre-planning group composed of five nurses	Self-initiated	1977 six months
Planning phase	Coordinating Committee composed of nine members, majority of whom were nurses	Established by the Ministry of Social Affairs and Health	1977-1979
	Two task forces, one was composed of ten senior nurses, the other was a multidisciplinary group (N=13)	One nominated by the Coordinating Committee; the other established independently to serve the local needs	1977 four months; 1977-1978 seven months
Implementation phase	Consultative Committee with sixteen members, multidisciplinary group chaired by a physician	Established by the National Board of Health	1979-1983
	Project Group with sixteen members of whom the majority were nurses, chaired by a nurse	Nominated by the Consultative Committee	1979-1984
	Responsible groups in Participating Centres	Established by local authorities	1980-1983

Table 4.1. The phases of the Nursing Programme and the levels of the organization

4.3.2. The pre-planning phase of the Nursing Programme

The pre-planning phase included international contacts and national efforts in support of the impending Nursing Programme. Considerable importance was given to the participation of five Finnish nurses in the session of the Regional Committee for Europe in 1976. That session was a significant one because for the first time in the history nursing was the topic of the technical discussions held at the 1976 session. The European Programme was introduced and discussed as a part of that event. This was the same occasion mentioned as a part of the context, as having provided 'a substratum' for the national development. The attempt was made to bring the message from the discussions to a wider Finnish audience but that event was cancelled, and no reason for that appeared in the documents.

On the whole, there were few documents from the early years when the preparatory discussions were conducted. For instance, there were no previous documents originating from the pre-planning phase in the archive of the Ministry of Social Affairs and Health, which would have provided a background to the final establishment of the Nursing Programme. The written material which was located in the archive of the Nursing Programme revealed the feelings of the nursing community. Nurses felt that matters related to the Nursing Programme were handled by the government authorities in a manner which reflected the subordinate position of nursing in society. There seemed to be a discrepancy between the official reactions and the reactions of nurses. It was observed that willingness to collaborate and to develop services was emerging from different parts of the country. It was observed as well that nurses were astonished that they were fortunate enough to experience such an attention shown to their work. And finally, it was asked who could take the responsibility for extinguishing such an enthusiasm.¹ Finnish nurses were active themselves and were supported by their colleagues in the WHO/EURO Nursing Unit. All the efforts seemed to focus on the appointment of an official planning body to give form and content to the European ideas about the Medium-Term Programme in Nursing/Midwifery.

¹Memoranda stating the significance of the Nursing Programme 25 May 1978 and 16 June 1978

This first period is explored through the work of the pre-planning group. The members of this group began to work together spontaneously stimulated by a visit of the Regional Officer for Nursing from the WHO/EURO. As a prerequisite for working for the Nursing Programme, this group listed such qualities as understanding of the concept of nursing, expertise in nursing and knowledge about broad areas of the health service system and courageous motivation for developing nursing.¹ Yet, the group indicated that the internal structure of nursing was not clear even to those nurses who were considered experts and that the language of the Nursing Programme was a problem.² It assumed that even within that group members may have a different understanding of concepts such as basic care, specialized care and nursing. Yet, it was decided to avoid a final definition of the [core] concepts.³ Behind this decision was the expectation that an extensive national discussion would clarify the concepts.

As one of its first tasks the pre-planning group attempted to plan the overall design for the Nursing Programme. The national health administration with its five-year plans formed the first level of the design. It was believed that the Nursing Programme should be integrated into the priority areas of research and health services documented in the five-year plans. It was suggested that the Nursing Programme should be applied under the auspices of the National Board of Health and integrated into the administration of health services at the local level. Health centres and hospitals, those which actually delivered services, and were the focus of the Nursing Programme, formed the next level in the structure. The third part of the design was a research centre and scientific research. Scientific evaluation study as a part of the design was also noted.⁴

Through its deliberations, the pre-planning group was outlining the rationale in the implementation of the coming Nursing Programme.⁵ It was developing an approach whereby nursing could be reoriented in practice settings from a task-centered pattern towards a professional one. This approach was described by stating that the organic growth towards the new practice pattern was necessary, and that it should be based on

¹Memorandum June 1977

²Minutes of Meetings 12 October 1977 and 16 November 1977

³Minutes of Meeting 9 March 1977

⁴Minutes of Meetings 3 March 1977 and 23 March 1977

the spontaneous growth of the participating units. Adoption of this approach, required the early involvement of the participating units and it required as well, that the Nursing Programme should begin on the unit level and be based on the terms of reference stated by the units themselves. It was understood that the Nursing Programme should support that spontaneous growth, for example, by providing it with information, but it was believed that the approach 'should not import polished, strange implements'.¹ This was stated though the members of the group had the experience that the working units may even accept directives.

Another broader issue dealt with by this group was the selection of the nursing practice areas on which to focus the development activities. The discussion started with the identification of what was called 'the basic situations in nursing'. These were defined

as such holistic entities of nursing practice which are encountered in reality, and in which both general and undifferentiated principles and methods of nursing as well as differentiated principles and methods required by a particular need situation, are applied. (Memorandum 4 September 1977)

In this connection it was stated that instead of employing an organization (e.g. school, health centre or hospital) or medical speciality (e.g. surgical nursing or pediatric nursing) as a denominator of the basic situation, the goal was to create a nursing oriented approach. Identification and classification of those basic situations in nursing proved to be very difficult in a short time which was available for the group. Therefore, the group stated the criteria for selection of the nursing practice areas. The criteria, suggested for the inclusion of centres into the Nursing Programme were: (1) settings which with reasonable efforts of the organizers would lend themselves to development; (2) settings which would yield information for broader application and generalization; (3) settings which would allow integration into on-going projects; the rationale for this suggestion being that it would lead to appropriate use of resources; and (4) settings through which the most urgent needs for development could be addressed. Following its own idea about nursing situations, the group prioritised five

⁵Minutes of Meetings 3 March 1977 and 9 March 1977

¹Minutes of Meeting 9 March 1977

areas as independent of existing organizational boundaries. The suggestion included primary health care services; the gynaecological area; the area of heart diseases; the psychiatric area; and developing health services for the elderly.¹

Several aspects concerning the nursing process were documented. These illustrated both how the nursing process was conceptualized and how it was planned to be employed in the practice of nursing. It was felt that there was a need for finding integrative solutions for the nursing process, such as theoretical foundation. Furthermore, there were four kinds of suggestions in regard to a more concrete work with the method of nursing process. As a broad starting point, a classification of nursing situations was mentioned, and it was stated that 'the aim is to develop specific implements for every nursing situation'.² It was noted that there were implications for nursing management when the nursing process was employed as well as the possible need for reorganization of nursing work. Included into the plan was the creation of a classification of nursing problems. Participation of the patient or client in the assessment was noted. Development of nursing interventions was mentioned as one task, and finally, measurement of the outcomes was considered important. According to the group, theoretical work and experimentation in practice was required to accomplish work in regard to nursing process. The pre-planning group also considered the general requirements for the establishment of the Nursing Programme.³ As such were mentioned, for example, a national position paper which would include clarification of concepts; a model for the organization of the development activities; and a research centre because 'the fact is that the essential idea of the Medium-Term Programme in Nursing is to create a scientific foundation for nursing'.⁴

Discussion There was a recognized need for professional development among Finnish nurses and the European Programme seemed to provide a vehicle for this development. Against this background the spontaneity of the group can be understood. This pre-planning group was innovative, it worked from sheer interest

¹Minutes of Meeting 4 September 1977

²Minutes of Meeting 9 March 1977

³Minutes of Meeting 23 March 1977

⁴Minutes of Meeting 9 March 1977

and it created the basic philosophy and structural ideas for the Nursing Programme. The group itself as an organization operated like a brain, but in suggesting unit-based organic growth of Participating Centres, it saw the future Nursing Programme operating like brains as well, with some organic features. From the professional perspective, the suggestions about nursing situations, classification of nursing problems, development of nursing interventions, and development of outcome measures were highly regarded items. Yet, it may be argued that the group was too much bound to nursing's perspective and not ready to take a client's and patient's perspective as a point of departure when the new outline was shaped. This group selected the categories of patients and clients for the Nursing Programme with great care. This group also exhibited some feature of an organic organization in its effort to link the Nursing Programme to the existing health service system.

In three respects this group generated ideas which shaped the final Nursing Programme. It suggested the principle of organic growth of the Participating Centres and participants in a manner which included an element of self-government. This principle was further elaborated by the Coordinating Committee. The group also gave the seeds for the content of the Nursing Programme though its suggestions as such were not followed. It also generated the idea of linking the Nursing Programme to the health authorities. This idea as well, was further elaborated by the Coordinating Committee. It is argued that on the one hand, that was a rational and most probably a necessary arrangement; but on the other hand, it included a mechanistic vision of forcing the health authorities into taking nursing seriously. A chain of authority exploitation was thus created, first by using the authority of WHO, and then making preparations for utilizing the authority of the National Board of Health.

4.3.3. The planning phase of the Nursing Programme

4.3.3.1. General themes in discussions

This second phase of the Nursing Programme is presented mainly based on work done by the Coordinating Committee. Only a short reference is made to its task forces: one of them contributed especially to the establishment of a long-term care project, and the other one contributed to the developments at the local level. The following themes will be described and analysed in this sub-section: the general atmosphere in regard to planning; designation of a WHO Collaborating Centre; matters related to the content and structure of the Nursing Programme; resources; the professional language; and informing mass media/others.

In the preceding section it was noted that the efforts of nurses were focused on instituting an official planning body for the Nursing Programme. According to its minutes, the Committee existed as a result of the efforts of nurses. This Committee

desired that the Nursing Programme become an apparatus for the development of nursing as a whole¹; but it stressed other matters as well, as the quotations show:

There is a need to clarify what is the academic subject matter which is different from medicine and social sciences. The Coordinating Committee builds on the existing knowledge, there is a need to know the content of nursing. (Minutes of Meeting 28 December 1977)

The ultimate goal of research and development in nursing is to improve health services. (Minutes of Meeting 9 August 1978)

Though the Coordinating Committee was quite an achievement, nurses were not pleased with the manner in which planning of the Nursing Programme was organized. They recognized lack of seriousness, undervaluation, and a tendency towards isolating nurses to work alone with the Nursing Programme, though the main goal of the whole effort was to develop health services by developing nursing and therefore a concern of the health authorities as well. Particularly, the absence of health administrators and physicians was considered problematic. It was noted that those who had not committed themselves to the effort, were free to ridicule the whole project.²

The Coordinating Committee seemed to have had an important mandate to make a statement about one topical issue of the time, namely, the designation of a WHO Collaborating Centre in Finland. Because there were two institutions willing to become a Collaborating Centre, both tried to demonstrate their suitability for the novel international position. Great importance was attached to the intellectual tradition in nursing as a basis of the Nursing Programme, and the impact this kind of collaboration would have in fostering the development of nursing. For that reason the Committee supported the designation of the Nursing Research Institute as an official counterpart to the WHO/EURO.³ It was the first nursing research institute in Europe, and it had collaborated with WHO before the Nursing Programme. The Institute was

¹Minutes of Meeting 4 May 1977

²Memorandum stating the significance of the Nursing Programme 16 June 1978

³Minutes of Meetings 9 March 1978 and 12 April 1978

finally the selection of the Ministry of Social Affairs and Health as well, which meant that it became a WHO Collaborating Centre in Finland in 1979.¹

The members of the Coordinating Committee were informing various authorities, university faculty members, organizations, and representatives of similar projects about the Nursing Programme. By these activities the Committee was seeking collaboration and doing groundwork for the content and structure of the Programme. In addition to the chairperson and the secretary, members of the Committee had assignments in promoting the joint effort. This Committee took the position that the Nursing Programme should be implemented as an official research and development project of the National Board of Health and that it should also be linked with the national five-year plans.² Among other things, the Committee considered seriously the opportunity to establish an experimental nursing education programme, possibly with the financial support of the WHO/EURO.³ The nature of the experiment was described by mentioning that the sharp distinction between theory and practice would be broken and research would be integrated into the subject matter of nursing. To intensify its efforts generally for the Nursing Programme, this Committee made an attempt through the Ministry of Social Affairs and Health to raise its status as an official planning body but did not succeed.⁴

Resources for the Nursing Programme was one thread which ran through the minutes of the Coordinating Committee. First, that group applied for resources for its own functioning and it got a secretary and nominated two task forces to become important cognitive resources for the application of the Nursing Programme. For that reason it was imperative to provide funds for these two groups (i.e. fees and travelling costs). The Committee went on and applied for funds from the National Board of Health so as to be able to hire a full-time worker for the project. That resulted in the recruitment of a nurse Programme Manager at the end of 1977.⁵ The placement of that person in the premises of the National Board of Health meant also a considerable resource to the

¹Minutes of Meeting 30 August 1978

²Minutes of Meeting 28 December 1977

³Minutes of Meeting 9 March 1978

⁴Minutes of Meeting 26 October 1977

⁵Minutes of Meeting 21 June 1977

Nursing Programme. The location of the Programme Manager became the Centre of the Nursing Programme.

One of the concerns expressed was that the would-be Participating Centres were informed in time to enable them to do their own planning and budgeting. Through negotiations, the Committee attempted to confirm that funds would be available for necessary expenditure on a continuous basis. Translation of the documents from English to Finnish was an area considered to require special resources. At one point in time, the Ministry of Social Affairs and Health had offered the necessary resources for translation.¹ Occasionally, the Committee exhibited a controlling attitude in regard to personal and financial resources in defence of nursing.² Once during the office of the Consultative Committee, the old Coordinating Committee was called to help in financing, and on that occasion it requested that the resources budgeted for a cancelled WHO nursing meeting be used for the Nursing Programme. The Coordinating Committee succeeded in securing that money for nursing.

The Committee was facing the problem of underdeveloped professional language, and it declared that an attempt should be made to focus on the concepts and terms in use so as to make them permanent parts of the professional language.³ Specification of nursing concepts was linked with the documentation, which meant that the nature of the clinical language was perceived as a part of the more general problem of professional language.

When the members of the Coordinating Committee informed all possible parties about the Nursing Programme, some would-be Participating Centres received information as well. Various channels were employed in informing about the impending Nursing Programme. Apart from that, two approaches to health centres and hospitals were employed. In regard to health centres, the minutes showed that the Committee decided to wait for the results of a survey which the Department of Primary Health Care (a Department in the National Board of Health) was conducting on the research and

¹Minutes of Meeting 21 June 1977

²Minutes of Meetings 10 May 1978 and 17 August 1978

development projects in health centres. Some dissatisfaction was shown towards that approach, and indeed, the results of that survey never appeared in the Committee. Various hospitals were approached by an information letter which inquired about the existing projects in the hospitals but also tested the interest and willingness of those hospitals to participate in the Nursing Programme. The Committee was pleased with the response it received.¹ The information about the Nursing Programme which was employed in recruiting Participating Centres was based on the interim report which is introduced next in this text.

4.3.3.2. The interim report of the Coordinating Committee

The major contributions of the Coordinating Committee to the Nursing Programme were two planning documents, the interim report (January 1978; 25 pages + appendices) and the master plan (December 1978). The latter will be introduced as a part of the implementation phase because the plan in principle formed the basis for the work of the Consultative Committee and the whole research and development project. The content of the interim plan is outlined in this section because it highlights the manner in which the needs for development in nursing were comprehended. Three areas of that report are dealt with here: (1) the identified national problems which indicated the need for a research and development project and the positive factors which created prerequisites for a new type of effort; (2) the rationale for the implementation of the Nursing Programme; and (3) the proposed content of the Nursing Programme. In exhibit 4.1., the national problems identified as indicating the need for focused research and development are presented. The problems seem to cover many and essential elements conventionally addressed in the profession of nursing.

³Minutes of Meeting 21 June 1977

¹Minutes of Meeting 9 August 1978

The absence or scarcity of research in nursing.

The scarcity or underdevelopment of analysis of concepts and theory of nursing and a general confusion of concepts and terminology of health services.

Lack of understanding of the contribution of nursing, and the role of nursing personnel in the total health services.

Lack of clarity of the division of functions between various categories of health personnel; this included the lack of understanding of the need for a rational nursing personnel system and numbers and proportions of personnel required within this system; the personnel structure was qualitatively and quantitatively often not related to the client and patient profile and/or to the need situation.

The need to define the quality and quantity of required nursing personnel was reflected in nursing education; problems existed in regard to recruitment, to maintaining and conveying a realistic picture of nursing and in regard to the content of education.

A tendency to adhere to outdated and inefficient management models, which as far as nursing was concerned had resulted in a sub-ordinate role which had hampered the development of nursing, legislation and regulations concerning nursing and health services in general changed slowly and frequently outdated regulations were an obstacle to the efficient utilization of resources.

Existing nursing development projects were not sufficiently co-ordinated.

Exhibit 4.1. National problems identified in the interim report (1978, pp 9-10)

At the same time several positive factors were identified which encouraged the planners to propose an extensive project. The following positive factors were mentioned in the interim report:

The increase in volume of nursing research and the gradual consolidation of the position of nursing research which was exemplified by the allocation of general funds for the Nursing Research Institute.

The official acceptance of higher education in nursing exemplified by the issue of directives to three universities concerning degree programmes in nursing.

The existing standards of education for health personnel and state financing which facilitated flexible educational planning.

The legal and functional framework of health services which was permissive in regard to development and enforcing in regard to administrative planning methodology.

The consolidation of international contacts or relationships in nursing.

Exhibit 4.2. Positive factors identified in the interim report (1978, pp 10-11)

The report included three principles for the implementation of the Nursing Programme. Cooperativeness and rational use of resources was the first of them (p 12). This meant the integration of the Nursing Programme with such projects or other

types of developments which had points in common with nursing. The examples given included academic and non-academic nursing education, several health service development projects, particular projects of the Finnish Hospital League, and the research studies of the Nursing Research Institute.

The fullest possible utilization of the support provided by the WHO European Programme was the second principle, and it was stated that 'the attempt will be made to utilize the Nursing Programme as an impetus for starting much needed national projects' (p 13). As an appendix to the interim report, there was a list of events - external to the Nursing Programme - with objectives coinciding with those of the Nursing Programme, to which the Nursing Programme was intended to be linked. Included were wide areas of research development and research utilization; education and teaching/reference material; and development of the content of services.

The third principle was to make good use of the Nursing Programme. It was noted that through sub-programmes, attempts will be made to produce functional models, new strategies, new implements, and new ways of collaboration. 'For this reason the implementation of the programme requires close contacts and cooperation with service and educational institutions' (p 13). Altogether 27 research and development projects were proposed and scheduled over the six year period of 1978-1983. To demonstrate the nature and scope of the original ideas generated by the planners, a summarized list of the themes is presented here.

Care of several groups of patients Experimental and/or other research projects on care of diabetics, care of cardiac infarct patients, care of short stay surgical patients, care of the elderly, and a long-term care project.

Systematic nursing Studies concerning the feasibility of systematic nursing intervention and its effectiveness.

Nursing education Development of written material which can be used in the guidance of school leavers in order to give a realistic picture of nursing as a profession; development of selection procedures for nursing education; developing the core content of education, research training, and clinical teaching; developing teaching and reference material for nursing education; developing collaboration between the schools and the health service system; and the analysis of the relevance of nursing education to nursing practice.

Organization and management and resource planning Developing nursing management in health centres and hospitals, and especially on ward level; developing information systems in nursing; comparative international studies in

nursing personnel structure; developing manpower planning and nursing personnel system, and developing nursing administration at national and regional level. (The interim report, 1978, pp 15-19)

In its statement in June 1978 about the interim report, the National Board of Health considered the suggestion for the Nursing Programme to be unclear due to the fact that a too varied list of topics had been included in it. The Board recommended concentration on projects which were concrete and which could bring true benefit to the service system. Examples of such projects were care of diabetics, care of the elderly, and long-term care. The Ministry of Social Affairs and Health gave its opinion about the interim report in August 1978, and it also emphasized the importance of a concrete plan of action which could be implemented in spite of scarce financial resources.

4.3.3.3. The Nursing Process Workbook

At the beginning of the Nursing Programme, the nursing process was a means by which the betterment in nursing was believed to be achieved. Because that method and some related themes were considered significant to the introduction and the implementation of the Nursing Programme, the Nursing Research Institute in a working party prepared a Nursing Process Workbook (1979, Volumes I and II, together 92 pages) for Participating Centres. According to the Workbook (Volume I, p 2), the objectives in developing nursing were

- to become familiar with the basic ideas and thinking in the Nursing Programme;
- to adopt that thinking and develop it further;
- to analyse one's own practice according to the Programme ideas; and
- to develop nursing in a goal-directed, systematic and planned manner.

On the one hand, implementation of the nursing process was considered necessary but, on the other hand, a certain amount of freedom was given to the participants¹. The Nursing Programme was said to be a collaborative effort which built on practical expertise. A Position Paper on Nursing (Hall, 1974) mentioned earlier was translated and included in the Workbook, as was another WHO document which dealt with studies on nursing interventions (WHO, 1979b).

The Workbook introduced the building blocks of the Nursing Programme. Three sets of concepts with their definitions and/or descriptions were introduced and the conceptualization of nursing was declared to be one of the preconditions of the implementation of the Nursing Programme. The concept of nursing was introduced according to the Henderson definition (Henderson, 1966). The concept of the nursing process was introduced as defined by a Technical Advisory Group for the European Programme:

The nursing process is a term applied to a system of characteristic nursing interventions in the health of individuals, families and/or communities. In detail, it involves the use of scientific methods for identifying the health needs of the patient/client/family or community and for using these to select those which can most effectively be met by nursing care; it also includes planning to meet these needs, provide the care and evaluate the results.

The nurse, in collaboration with other members of the health care team and the individual or groups being served, defines objectives, sets priorities, identifies care to be given and mobilizes resources. She then provides the nursing services either directly or indirectly. Subsequently she evaluates the outcomes.

The information feedback from evaluation of outcomes should initiate desirable changes in subsequent interventions in similar nursing care situations. In this way, nursing becomes a dynamic

¹This term 'participant' refers to nurses who implemented the Nursing Programme in the Participating Centres. Both first level nurses and second level nurses were involved. Their roles differed based on their educational background. The authors of the final reports were all first level nurses.

process lending itself to adaptation and improvement. (WHO/ICP/HMD 049(1), 1977b, pp 2-3)

Terms like assessment, nursing diagnosis and documentation were separately discussed. In the second part of the Workbook, several examples of assessment tools and forms for documentation were given. The third set of concepts were standards and criteria, in other words, concepts which were essential in quality assurance. According to the Workbook the aim was to develop structure, process and outcome evaluation, and as a part of that, standards and criteria.

Two other areas of exploration and work were discussed in the Nursing Process Workbook. It was noted that a serious attempt was made to prevent a mechanistic approach in nursing. For that reason (and because ethical considerations were perceived significant) discussion was stimulated in the Participating Centres about the mission of nursing in the society, about its ultimate goals, and about the basic principles according to which it serves people. It was suggested that the identification of principles might lead to a statement of the philosophy of nursing for the practice settings and to the implementation of those principles in the actual practice of nursing (Volume I, pp 29-31). General approaches to nursing, which were also called 'frames of reference', were the other themes introduced as an ingredient of the Nursing Programme. These approaches were an integrating factor in the nursing process. Discussion was not extensive but Roy's Adaptation Model and Roper's ADL Model, along with functional and problem-oriented approaches were introduced (Volume II, pp 3-8).

In summary, the Coordinating Committee built the Nursing Programme, informed other agencies about it and sought support for it. Its major products were the interim report and the master plan of work. The interim report demonstrated that it was desired that the Nursing Programme give a general impetus for development and forward movement in nursing. The content of the Nursing Process Workbook gave a detailed account of the subject matter of the work. It discussed the principles underpinning nursing, its theoretical foundation, nursing process and evaluation.

Discussion In his analysis of machine-like organization, Morgan (1986) made a distinction between the instrumental rationality and substantive rationality. The former was mechanical and fitted the individual into a preset design of work. The latter invited the evaluation of the appropriateness of one's action and changes based on that evaluation, or in Morgan's words: 'substantial rationality requires actions that are informed by intelligent awareness of the complete situation' (Morgan, 1986, p 37). It was the substantial rationality type of action which was recommended as appropriate in the Nursing Process Workbook.

The major problems identified as a part of the context were transferred to the Nursing Programme. Such problems were the position of nursing in society, the nature and scope of practice, broad educational issues and conceptualization of nursing included in these educational concerns. Concerns related to nursing were very similar in Europe. It can be argued that it was logical to make an attempt in Finland to solve the problems with the support of the international and national part of the WHO Nursing Programme.

Another observation can be made on the continuity between the context and the planning phase. One of the most painful problems had been the exclusion of nurses from the significant decision-making, and the new service regulations did not seem to remedy the situation. In the early phases of the Nursing Programme, nurses were included and everybody else was excluded. In other words, the Nursing Programme was entirely in the hands of nurses. But nurses complained about this. Certainly, a project such as the European Programme could not have been applied without government connections. But the basic attitude of nurses did not exhibit logical reasoning. Furthermore, nurses showed extreme naivety and lack of sense of history in demanding collaboration of physicians and health administrators. Through the history of the nursing profession, there has been controversies between nurses and these two groups (i.e. doctors and administrators).

In the organizational context, both unsolved concerns and unused potential were found. Therefore, the struggle for survival of the Nursing Programme was justifiable. The Coordinating Committee was focusing on the survival issues. This Committee

was sensitive to the organizational needs. With its operations, it attempted to obtain resources which would satisfy organizational needs. The Committee also acknowledged the learning needs of the participants, and it showed great concern for proper timing in informing the Participating Centres so that they in their turn could meet their organizational needs (i.e. planning in time and obtaining resources).

The environment of the organization, from where the resources for the Nursing Programme had to be obtained, was not an easy one. It was the environment which had not granted nursing an identity by allowing it to have a name. In the most critical sense the environment had not any previous experience of dealing with purely nursing matters. Therefore, the question of survival was essential. There were probably four factors which finally made the Nursing Programme survive, and they were: (1) the Nursing Programme was officially connected with the national health authorities; (2) it had some resources of its own though the origin of those resources was government funds; (3) the Nursing Programme had counterparts in the field in several Participating Centres; and (4) the perseverance of nurses was the unfailing undercurrent. The Committee first employed the positive answer of the Finnish government to the WHO/EURO as a psychological niche in the environment. Later, it secured a niche by obtaining some financial and personal resources.

The Coordinating Committee was liberal and in constant collaborative interaction with its environment. It was contacting, informing, and negotiating. Only one area in the environment was identified as not contacted, though according to the minutes there was the intention to do so. That area contained those nursing organizations which were not involved in planning of the Nursing Programme. The reactions of the environment gave birth to the first Participating Centers. The Committee showed respect for its two task forces though in matters of crucial importance to nursing it followed its own path. Only seldom did it exhibit a controlling attitude. That happened when it had to guarantee that only nursing was promoted with the scarce resources of the Nursing Programme. But there were no competitors of the Nursing Programme which would have taken the interest of nurses to other matters. The Nursing Programme was the first of its kind which aimed at involving practicing nurses and which at the same time, in its success, was entirely dependent on their response. The

only controversial element during the office of the Coordinating Committee was the designation of a WHO Collaborating Centre in Finland.

In its capacity for information processing and in the imaginative content of the interim report whereby (if totally applied) it could have solved all the problems in the profession of nursing, this Committee exhibited some features of a brainlike organization. It was innovative and showed independence of the earlier unsupportive environment. It is quite evident that the interim report included a professional agenda though it was equally evident that the profession of nursing had experienced serious problems which were not recognized by the environment. However, the major organizational image of the Committee was that of an organic organization. It secured a niche for survival, it was sensitive to organizational needs, and it was openly collaborating with its environment. And yet, the organizational design it gave as a heritage to the Nursing Programme was a mixture of organic and mechanistic orientation. That is discussed in the next section.

4.3.4. The implementation phase of the Nursing Programme

4.3.4.1. The master plan for the Nursing Programme

According to the master plan (1978; 36 pages + appendices), the Nursing Programme was designed in such a manner that it would be parallel with the national five-year plans for health services (p 14). The objectives of the Nursing Programme have been stated in the introductory chapter. The rationale for the Programme implementation was not extensively discussed but some ideas were documented. The planners tried to avoid the establishment of a separate and very heavy organization. They rather perceived the Nursing Programme as being applied based on institution-specific plans and budgets. The attempt was made to build on the nursing expertise existing in the Participating Centres, and from the very beginning, to make systematic development an integral part of nursing. It was planned that within the organization and management component, the prerequisites for a dynamic, continuous development should receive special attention (p 24).

The Centre of the Nursing Programme was given the tasks of planning, coordination, and participation in the implementation of the project. The Centre was perceived as a cooperative unit between the WHO/EURO and the national project. It was projected that in case the Nursing Research Institute should become a WHO Collaborating Centre, the functions of the Centre and the Institute would merge. According to the plans, apart from the Programme Manager, two investigators and one research assistant were placed in the Centre. Research resources of its own were considered significant because research had methodologically, organizationally and, in terms of content, an important role in the Nursing Programme (pp 30-32). Implementation and coordination on the whole were said to require necessary financing from government funds.

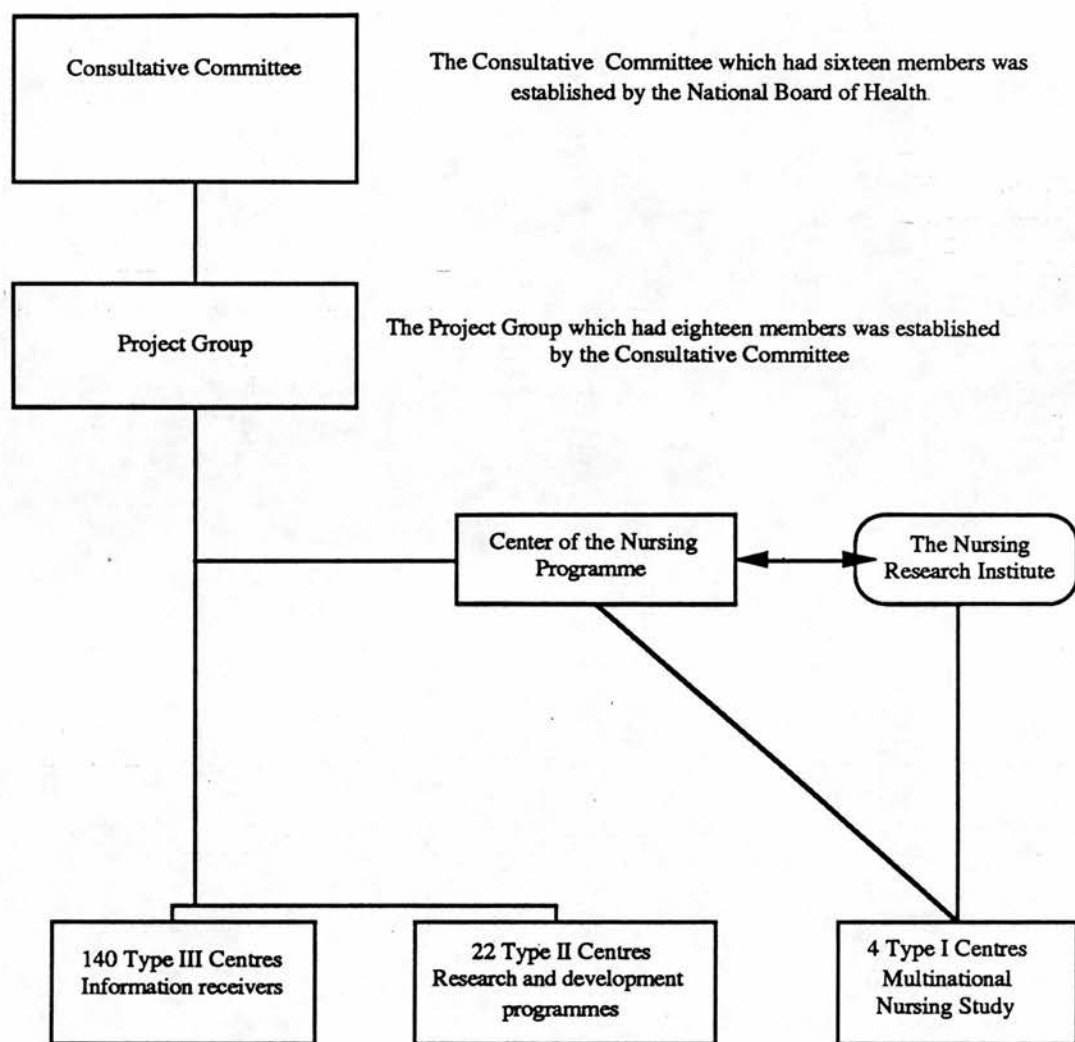


Figure 4.1. The steering organization of the Nursing Programme

Both the organizational chart and the members of the Consultative Committee were designed in the Coordinating Committee. The organization of the Nursing Programme is presented in Figure 4.1. in the form it was put into effect. In the master plan, an analysis was presented which linked the Nursing Programme with: (1) various health authorities, (2) educational authorities and educational and research institutions, with (3) the international field, and (4) with professional organizations. The majority of these interest groups were represented in the Consultative Committee. The Coordinating Committee required of the members of the Consultative Committee that: 'It should be confirmed in advance that the would-be members of the Consultative Committee are convinced of the necessity and significance of nursing research'.¹

¹Minutes of Meeting 15 November 1978

Figure 4.2. shows the organizations represented in the Nursing Research and Development Programme.

Health service system and its administration	Coordination of the Nursing Research and Development Programme	Educational and research institutions and their administration
Ministry of Social Affairs and Health National Board of Health National Board of Social Welfare Provincial Boards Department of Social Affairs and Health Health Centres Hospitals Finnish Hospital League Association of Finnish Cities Finnish Municipal Association	World Health Organization Regional Office for Europe International cooperation	Ministry of Education Universities National Board of Vocational Education Schools for Health Personnel Production of teaching and reference material
Professional organizations related to nursing		

Figure 4.2. The Nursing Programme and its interest groups

LIFE SPAN

TYPE OF A PARTICIPATING CENTRE

Pregnancy and birth	Childhood	Schoolage	Youth	Adulthood	Old age	Health centres
Growth towards parenthood in the family expecting its first child	Counselling pupils on fifth grade in human relations and sexual behaviour	Counselling students in upper secondary school in human relations and sexual behaviour	Supporting self-care of people at working age who suffer from overweight	Group counselling of clients suffering from high blood pressure	Maintaining independence of the elderly patients	Health centres
Family-centered nursing in a MCH clinic (N=2)	Promoting mental health in a school environment	Offering nursing at home to clients suffering from multiple sclerosis	Developing patient/client classification system for home nursing	Developing long-term nursing care (N=2)	Developing counselling for the elderly	
Child health care and upbringing (11 centres)		Occupational health nursing at workplaces	Developing home nursing for the demented elderly (N=2)	Maintaining independence in long-term nursing care	Promoting and maintaining health of people living in a residence for the elderly	
Nursing in the prenatal clinic, delivery room and on the maternity ward (N=2)	Nurse-patient interaction and its documentation on a psychiatric ward	Promoting self-care of the patients suffering from diabetes	Counselling diabetic patients for discharge from the hospital	Project covering nursing in the following environments: medical, surgical, ear-nose-throat, and ophthalmological wards	Rehabilitative approach in long-term care in institution and in community	Hospitals
Supporting parents of chronically ill and disabled children	Teaching self-care to patients suffering from asthma	Psychiatric nursing: nursing interventions in support of patient's participation in their own care	Goal-directed/rehabilitative nursing of patients suffering from collum fracture (N=2)			
A demonstration project in nurse education: teaching the main subject	Intensifying the admittance phase in patient care on a psychiatric ward	Nursing care of stroke patients at all hours of the day				
	Developing teaching of Nursing: correspondence between nursing, education, and professional identity					Schools

Figure 4.3. The topics of the nursing research and development projects according to the life span and the type of the Participating Centre

The master plan included eight sub-programmes. These eight projects were the seeds of the final Nursing Programme. Figure 4.3. includes all the completed and reported research and development projects which are presented according to two continua: life span and the type of Participating Centre.

4.3.4.2. The steering system of the Nursing Programme

In this section, operations of the Consultative Committee and the Project Group are discussed. Together these two groups formed a steering system for the Nursing Programme and the project progressed as a result of the interplay between these two bodies. According to the letter of appointment, the function of the Consultative Committee for the Nursing Programme (May 1979 - December 1983) was to coordinate the plans of action as well as the budgets, to secure the financial resources, and to supervise the Nursing Programme. The Committee itself declared that it would deal with only broad policy issues and on a very general level it would direct and monitor the Nursing Programme¹. The function of the Project Group was to prepare the content of the Nursing Programme, to follow the growth of the Programme, and, if required, to give expert assistance to the Participating Centres². The Project Group had the mandate to accept the reports for the publication series of the Nursing Research and Development Programme. Approval of annual plans and budgets and acceptance of progress reports and accounts of financing of the Nursing Programme, were the important functions of the Consultative Committee. The same administrative material went first to the Project Group and occupied many of its meetings. In the following discussion, matters of importance in the light of the objectives of the Nursing Programme, are presented.

Two elements in the context of the Nursing Programme were reflected in the operations of the steering system. First, the simultaneous changes in nursing

¹Minutes of Meeting 14 August 1979

²Minutes of Meeting 26 November 1979 (Consultative Committee)

education, particularly in the academic education, actualized discussion about the nature of nursing and its knowledge base. Disagreement about these crucial matters became an obstructing factor in the Nursing Programme. In the Programme, an attempt was made to follow the international development in nursing as it was manifested in the WHO network, and the disagreement was never openly discussed. The other element was the debate about a reform of regulations governing decision-making in health centres and hospitals. This debate was concerned with the positions of nursing and medicine in the health service systems. This issue had an impact on the Programme which actively promoted nursing, but the issue was not openly approached by the members of the steering system. Conflicts between the interests of the members of the steering system were not only academic by nature but they had an impact on Programme functioning.

Planning documents The Consultative Committee had twice on its agenda discussion of the master plan but it was never discussed¹. On the second occasion it was decided that the Project Group should prepare that topic for the Committee but that did not happen. However, there was a third planning document called Concrete Objectives of the Nursing Programme, and that was commented on by the Committee. Concrete objectives were prepared in 1981 and introduced as a document which described the expected outcomes of the Nursing Programme. Detailed descriptions of all research and development projects (N=39) were included in this document in the form approved by the participants themselves. There were other content items as well, and they included all the work which the Project Group had planned to accomplish for the Nursing Programme. This document showed that all four areas of the European Programme would be dealt with.

In summary, the items described in the third planning document included: (1) recording of principles of nursing and compiling concepts of nursing; (2) documents about the nursing process; (3) an experimental programme in nursing education and recommendations concerning in-service education; (4) suggestions concerning the advancement of nursing research; (5) report on the state of nursing management, which was expected to provide a basis for work on that area; (6) topics like patterns of

¹Minutes of Meetings 16 October 1979 and 26 November 1979

nursing, developing nursing personnel system and nursing environments; (7) report concerning the cultural aspect of the Nursing Programme; and (8) a nursing policy document for 1980-1990. The outcomes of these concrete projects were mainly written documents which summarized the level of thinking and practice reached with the collaborative efforts in the Nursing Programme. It was noted in the statements of the participants in regard to this document that on the one hand, it will assist in focusing the scarce resources, but on the other hand it was believed that the document does not prevent the creativity to emerge.

The description of the content of the third planning document shows clearly that it covered a wide range of demanding projects, some of which were said to require additional resources. This last overall planning document was twice on the agenda of the Consultative Committee¹. According to the minutes, the projects of health centres and hospitals were not discussed. Alterations suggested concerned integration of research and education and strengthening the research element; furthermore, the development of academic subject matter was added to the agenda of the Project Group. No follow-up or support of these changes, which mainly belonged to the mandate of the Ministry of Education and the universities, were documented afterwards. As a part of the plan, a suggestion was made to consolidate the position of the Project Group so as to give it a better opportunity to prepare a nursing policy document for coming years. According to the third planning document, the change in the status of the Project Group was the task of the Consultative Committee. The Committee expected that the Project Group clarified its idea and the Committee would deal with it later². This did not happen.

Nursing education Education was an issue and a concern identified by the Consultative Committee. It was also a broad target area in the overall objectives of the Nursing Programme. A concern was expressed at the Committee that the new educational system will lower the level of nursing personnel³. Similarly, the Project Group contended that knowledge and skills relevant to future nursing were excluded from the educational plans, and this Group considered this topic significant and

¹Minutes of Meetings 4 February 1981 and 11 May 1981

²Minutes of Meeting 11 May 1981

³Minutes of Meeting 26 May 1980

requiring further discussion. The Committee decided that nursing education would be discussed in the presence of the member who had drawn attention to the educational issue.¹ In the remaining two and a half years, that person did not appear in the meetings of the Consultative Committee, and consequently, nursing education was not discussed.

Professional language The development of professional language was also a broad single target area. The concept 'nursing' appeared once per year on the agenda of the Committee in some form or other. At the beginning, the Committee showed appreciation of the conceptual development in the Nursing Programme. In 1982, it was documented that the Finnish translation of nursing, 'hoitotyö', had several other meanings than nursing², and in 1983 it was documented that 'at this point the word nursing is causing trouble in the establishing of an expert committee on nursing'³, which at that time was on the agenda of the National Board of Health. Finally, in 1983, it was recorded that the National Board of Vocational Education did not use, in nursing education, the concept of nursing in the manner it was used in the Nursing Programme.⁴ Nothing appeared in the documents which would have shown that the Committee was concerned about the developments around this key concept. Discussion about concepts and language appeared through the years also on the agenda of the Project Group. The Group seemed to believe that the National Board of Health should officially confirm that nursing was a unique sector of the health services.⁵

Information sharing Informing the public through mass media about the Nursing Programme and its progress became an issue as well. The Consultative Committee documented its deliberations e.g. that 'it is necessary to inform, to prevent misunderstanding and to avoid placing the whole Nursing Programme in a bad light', and 'the Nursing Programme may be at risk of having a detrimental influence on the

¹Minutes of Meeting 22 September 1980

²Minutes of Meeting 9 March 1982 (Consultative Committee)

³Minutes of Meeting 21 March 1983 (Consultative Committee)

⁴Minutes of Meeting 19 December 1983 (Consultative Committee)

⁵Minutes of Meetings 6 January 1982 and 7 February 1983 (Project Group)

spirit of solidarity in the health service institutions'.¹ Through several discussions, the Project Group formulated its policy which was in favour of informing about the Nursing Programme. An outsider, attending the meeting of the Consultative Committee, advised the Committee not to provide information through the mass media, as the Nursing Programme would not benefit from that. It was added that the terminology and theory employed in the draft press release would not promote the project. The Consultative Committee decided accordingly² and the Project Group supported the decision³. There was no explanation in the minutes for this change in the policy of the Group, but there were some signs of dissatisfaction among the members. Informing mass media was included in the plan of activities of the Programme for that particular year. The following is a summary of the draft press release which the Consultative Committee believed to do harm to the Nursing Programme.

The Member States of WHO asked for assistance in analysing the function and position of nursing in the health services. Eighteen countries participate in the European Programme. In Finland, care of the elderly is one priority area, ten health centres and hospitals are working on that theme. The objective is to make care more humane and individual and to support self-care of the elderly. The results show that with existing resources significant outcomes have been obtained. The importance of research, knowledge base and in-service education were noted. As in medicine also in nursing, practice based on research was appreciated. 160 health centres, hospitals and schools participated in the project. Among the participants interest was shown towards the international views. On the European level, positive experiences had been gained in research collaboration and in practice-oriented projects.

Resources At the beginning of its office the Consultative Committee asked for information about the financing of the sub-programmes in the Participating Centres⁴, and once the Committee appealed to its members that they do their share in securing funds on the local level⁵. According to its minutes, the Committee did not concern itself with the financing of the Centre of the Nursing Programme which never received the planned resources for investigation. Though the Project Group did not have any primary responsibility for financing of the Nursing Programme, it expressed its

¹Minutes of Meeting 17 December 1981

²Minutes of Meeting 9 March 1982

³Minutes of Meeting 6 April 1982

⁴Information about the financing of the sub-programmes 5 October 1979

⁵Minutes of Meeting 26 May 1980

concern regarding the financing.¹ The following three sections were repeated in the budgets for the Nursing Programme: salary of the Programme Manager; expenses caused by supportive measures, (i.e. education, consultation, and coordination) and financial management.

The attachment of the Nursing Programme physically to the National Board of Health brought to the Programme important resources though they were not budgeted for nursing per se. Those resources were the office of the Centre of the Nursing Programme, the opportunity to establish the publication series, and some secretarial assistance. On completion of the Nursing Programme, the National Board of Health provided financial assistance for the final reporting to some of the Participating Centres. The Ministry of Social Affairs and Health contributed to the financing of the Nursing Programme by paying the travelling expenses of the members of the Consultative Committee and the Project Group. An earlier promise given by the Ministry to contribute to the translation costs was not kept.

Description of the Project Group The Group was characterized by lack of continuity and rationale of its actions: it recognized and documented the importance of several matters which were normally included in the overall plan of the Nursing Programme and appeared repeatedly on the agenda, but the Group did not bring the matters to completion. Examples of such uncompleted items were the professional language, informing the public, accounts of nursing principles, need-based approach in nursing, the nursing process and nursing research, nursing administration and many items emerging from the document on concrete objectives. Nursing education (mainly non-academic) was eight times on the agenda of the Project Group. The Group expressed its concern in regard to the changing education but did not produce the intended statement. The Group had experienced some difficulties in its work and it actually once had on the agenda a discussion about its own working pattern.²

According to the plans, formulation of policies concerning the nursing process and nursing principles and the clarification of some key concepts were on the agenda of the

¹Minutes of Meetings 12 November 1980, 24 March 1981 and 4 August 1982

annual meeting of the Participating Centres. According to the minutes of the Project Group,¹ it was suggested that the participants, working in small groups, would prepare recommendations concerning the nursing process and nursing principles and their theoretical underpinnings (this included the introduction of nursing theories). Some preliminary analysis had been done in regard to the nursing process and nursing principles showing a wide coverage of these themes. A comprehensive report was planned to be produced and published, based on the deliberations of the Programme participants. It was assumed that the report could form a basis for discussion about nursing in the Consultative Committee. However, without any editing and without compiling separate group reports, the material was to be sent to the participants, and preparations for publication were discontinued.² The group never made any statements about those two items, and with this decision it lost the opportunity to discuss the key concepts included in the material. There was no previous material in Finnish compiled in such a manner.

In 1982, both the Consultative Committee and the Project Group identified and discussed, that the strategy 'Health for All by the Year 2000' provided an opportunity for continuing development activities. The Project Group showed enthusiasm and interest in beginning work on the HFA/2000 strategy.³ It was believed that the Nursing Programme had provided a precondition for moving in that direction. It was stated that the global health goal did not require any changes in the basic approaches in nursing. However, it was felt that a new kind of accountability would emerge from this global health movement. The Project Group continued work with this idea and prepared a Mini Scenario of Nursing which was published as an appendix of the project history. The Mini Scenario described what nursing would be like if the principles of 'Health for All by the Year 2000' were followed.

²Minutes of Meeting 5 October 1982

¹Minutes of Meeting 18 February 1982

²Minutes of Meeting 1 June 1982

³Minutes of Meetings 18 October 1982 and 3 November 1982

4.3.4.2.1. Activities supporting the participants of the Nursing Programme

There were three categories of activities which formed the actual enabling support for the participants. These activities were education, consultation and information delivery. All the support provided by the Nursing Programme to the participants was available free of charge.

Education Twice a year the Contact Persons had a meeting where topical matters of the Nursing Programme were dealt with. Twice a year the Nursing Research Institute organized courses in methods of research and development for the participants. The invitation and/or selection of participants for these meetings and courses do not appear to have been restrictive. However, financial restrictions (e.g. in terms of travelling costs) caused some limitations. In addition to the national meetings and courses, an attempt was made to use the resources of the Nursing Programme for locally organized educational events. With the support of the Finnish authorities and the WHO/EURO, some international experts were invited to share their knowledge with the Finnish nurses. A partly educational function was that of follow-up seminars which were annually arranged by the Centre of the Nursing Programme under the auspices of the Consultative Committee. In those seminars, Participating Centres presented their sub-programmes, and the Committee was in the position to monitor the progress.

Four meetings had special roles in the application of the Nursing Programme. The three day meeting which launched the joint effort in October 1979 was the first of them. Participants assessed the approach which was created for the Nursing Programme and described in the Nursing Process Workbook. Some criticism appeared but on the whole the approach was accepted. The participants clearly defined the preconditions required for the successful completion of the projects. The memorandum (4 January 1980) prepared after that meeting included the following requirements: written material in Finnish on crucial areas of the Nursing Programme, education for researchers and other participants, consultation, mutual information

sharing and information about nursing literature and continuous open collaboration which was considered to be a significant principle.

The following autumn, deliberations of the second important meeting were documented (10 October 1980). In discussion, views were exchanged about the ethical foundation of nursing and about the nursing process. The practical and administrative obstacles in the development of the content of nursing was one broad agenda item. This discussion built on a newly published WHO report on Nursing Services (WHO, 1980b). This report helped to launch the debate about management issues in nursing. Participants of the meeting thought that the development in nursing management was a favourable one and considered it useful that the conceptual clarification of nursing preceded developments in management.

In the year 1983 two events were recorded. A two day course was arranged for those participants who were responsible for writing final reports of their work. This short course aimed at supporting and encouraging nurses in literary work. Tentative outlines of research reports and development reports were prepared for the Participating Centres.¹ The other meeting was the very last collaborative effort where participants together evaluated the Nursing Programme. The key outcome of that meeting was that the participants expressed their readiness to continue research and development activities in their respective institutions without a special support mechanism. However, the desire was expressed that there would be opportunities for them to meet regularly also in the future.²

Consultation It was a special duty of the members of the Project Group to provide consultation to selected Participating Centres on a regular basis. All members who were available for consultation had their regular daily work responsibilities as well. It was noted in the minutes of the Project Group³ that these resources were limited and this topic was on the agenda of the Group until its last meeting. The Nursing Research Institute provided supervision for research projects. To be able to use scarce resources

¹Minutes of Meeting 6 April 1983 (Project Group)

²Minutes of Meeting 19 December 1983 (Consultative Committee)

in an efficient way, all Participating Centres were encouraged to build supervisory contacts with local resources, for instance, with universities and schools for health personnel.

Information delivery Information delivery covered all written material which would promote the implementation of the Nursing Programme. Publications of WHO, publications of the Nursing Programme itself, and the progress reports were the main content of information. The intention seemed to have been to produce a wide repertoire of nursing material in support of the Participating Centres. The themes for the material were the same as mentioned earlier as the content of the Concrete Objectives of the Nursing Programme. This intention was only partially fulfilled. In the progress report (September 1980) it was once noted that due to lack of resources the intended material was not produced. It was more common that plans simply were not realized. Taking into consideration the clearly expressed need for written material in Finnish, the fact that so much was left undone must have been an inhibiting factor in the Nursing Programme. There was one missing document which may have had special impact on the course of the Nursing Programme. That document was the account on nursing administration which was planned to give impetus to concrete work on that topic.

4.3.4.2.2. Synopsis of some progress reports

The steering system of the Nursing Programme was informed, in many ways, about the progress made in the Participating Centres. A small series of progress reports seemed to portray work on the Nursing Programme and achievements as they were perceived by the participants. A synopsis of these reports over four years is provided here to highlight the nature of information available for administrative purposes. The year of production of the document is indicated.

1980 Until that point there was no approved procedure identifiable in the health service system whereby problems and developmental needs in nursing could have been addressed. Similarly, procedures were non-existent which would reform nursing

³Minutes of Meetings 18 December 1980 and 21 January 1981

on a continuous basis - for instance, by introducing research results and international development - ; consequently much of the nursing capacity has not been utilized for the benefit of the health services. Even the well justified efforts to develop nursing were the targets of ridicule which made the promotion of the Nursing Programme unnecessarily hard. The nursing process was said to be a method that would remedy fragmentation. That method was perceived to lead to the analysis of important elements such as ethical principles and scientific foundation 'at this significant international and national stage of the development'.

1981 The Nursing Programme had progressed as expected. There were moments of slow progress or no progress at all. Those situations had been accepted as transitory or they had been solved by bringing in additional resources by offering education. A list of topics of interest in the sub-programmes were for instance primary nursing, continuity of care and collaboration required, basic principles of nursing, individual and humane nursing care, created new learning needs and supervision. Preparation of research proposals and project plans was considered a useful experience.

1982 Contact Persons, on request, described the outcomes they had observed in human resources and in the functioning of the systems in the following way:

An attitudinal change is observable in nursing personnel and examples are: a new way of thinking has been adopted and thinking has deepened on the whole, appreciation of and interest in one's own work, strengthening of professional identity and improved working motivation. Increased professional courage and self-confidence allows more open collaboration than was the case before.

Nursing personnel accepts and enables the participation of the patient and client and as to patients, they accept the activating model of nursing. Developing self-care and independence and general activation of the patients are essential. The patient's position is becoming more and more central in nursing. Nurse-patient interaction is more open than before. Participation of relatives and the immediate environment in care has increased.

Nursing has become more humane... Individuality and individual needs are important and give impetus to nursing. A holistic approach is becoming more and more accepted. A patient is perceived as a member of his/her family and of the society at large. Discussions cover broader and broader themes.

Systematic nursing has been accepted and is employed. Practice of nursing is goal-directed and better organized than before. Working in teams has

intensified. Information sharing and collaboration have improved. Other health professionals are consulted. Patient teaching has become more effective. Attempts have been made to stress the importance of continuity of care.

1983 At the last meeting of the Consultative Committee the following matters were reported to the members. A noteworthy pool of experts in nursing has formed. Nursing research in the health service system has begun and is partly established. In the Finnish discussion, nursing themes which are topical also in the international field, are dealt with with great competence. Collaboration has developed in a positive direction. International exchange has widened. Almost all Participating Centres reported that research and development will continue after the Nursing Programme.

There was one intervention at the end of the Nursing Programme which specially aimed at securing the utilization of the results and confirming some future measures. The Consultative Committee and the Project Group jointly prepared a letter for the Minister of Social Affairs and Health and the Director General of the National Board of Health.¹ These letters with similar content included the following recommendations: 1) nursing should be involved in the preparation of the 'Health for All by the Year 2000' programme; 2) a nurse researcher should be associated with the research team in the Ministry of Social Affairs and Health; 3) for the utilization of the results of the Nursing Programme and for securing further measures several suggestions were made, such as establishing an expert committee on nursing at the National Board of Health, regular meetings for former Contact Persons (jointly with the Nursing Research Institute), organization of further education; 4) publication of the results of the Programme; and 5) evaluation of the Programme in a seminar (an obligation left to the Project Group).

In summary, the master plan of the Nursing Programme was introduced. This plan was described by its objectives and the organizational arrangements for the Programme. The Concrete Objectives of the Nursing Programme and discussion related to this document was dealt with. Based on the minutes, annual plans and progress reports, the content of the work of the Consultative Committee and the

¹Minutes of Meetings 19 December 1983 (Consultation Committee) and 20 January 1984 (Project Group)

Project Group was discussed. The measures of the Centre of the Nursing Programme, education, consultation and information delivery were introduced. Finally, a series of short progress reports was summarized.

Discussion This level of the Nursing Programme never acquired a fully bureaucratic or mechanistic pattern, but it exhibited several features of it. From the perspective of nurses, everything seemed to have a relationship with the Nursing Programme. In other words, educational and health authorities, universities and various types of other organizations were perceived as interest groups or having interest in nursing matters (cf. Figure 4.2.). The composition of the Consultative Committee and the involvement of various parties was one indication of a mechanistic image. By definition, these various parties were expected to further the much needed projects in nursing. It was believed that physicians and health administrators through organizational arrangements would become a part of the research and development in nursing. A system of goals, objectives, principles and specified tasks was instituted by means of the master plan, and the organization was assumed to work in a rational manner towards the stated major goal. From this perspective it is significant that the Committee did not commit itself to the objectives of the Nursing Programme. Indeed, the Committee did not exhibit rationality - quite the contrary it was ambiguous and paradoxical - and it was not keen on objectives and preset tasks. Perhaps the fact that (according to the organizational design) it very clearly took its position at the top of the hierarchy reflected a mechanistic image more than anything else.

The structure of the steering system exhibited machine like images (cf. Figure 4.1.). Rational planning and regular control through the progress reports were also characteristics of the machine metaphor. The Consultative Committee paid little attention to the human aspects of the Nursing Programme, it directed and monitored, which was a mechanistic feature. The human aspects were brought to the attention of the Committee in terms of changes on the level of the patients and clients, and on the level of practicing nurses themselves. Participating Centres had documented step by step how the human resource had adopted a new way of thinking and working. Many positive observations were made mainly in regard to what in nursing is called the human encounter, open interaction and working together.

The follow-up seminars provided this Committee with the opportunity to meet the actual production level of the Nursing Programme. Certainly, the Committee was meeting its own information needs on those occasions as well. But it also satisfied the organizational needs of the participants by showing interest in the progress of the Nursing Programme. In this regard, the Committee exhibited the organic metaphor. The Committee, however, did not give serious consideration to the needs of the participants nor did it recognize the effect of the environment on the project.

The evidence seems to suggest that the organizational structure was designed to become a rational tool for the Nursing Programme implementation. The planners of the Nursing Programme believed that the launching, implementation and the outcomes of the Programme were dependent on the various parties (cf. Figure 4.2.) which were represented in the organizational structure. But this structure when put into action made it possible to use it for political purposes as well. One prevalent feature of the major organizational element, the Consultative Committee, was that it brought into the Nursing Programme a diversity of interests. The spectrum of the interests of the Project Group was not wide in a similar manner. There were at least three types of orientations and interests. There was a marked indifference in regard to nursing as exemplified by two big national organizations. Their annual reports or main organs did not contain any information which had originated from the membership and promoted the ideas developed in the Nursing Programme. There were several authorities and organizations which were simultaneously involved in actions which were completely against the work the Committee was supposed to direct and monitor. This was the case in regard to several educational matters and with the professional organization of nurses. There were few members who in their working life and in their other roles in the society were working towards the goal identified in the Nursing Programme. These members most probably made an effort to promote the Nursing Programme in their role of Committee members as well. In regard to its membership, the Consultative Committee was paradoxical. Taking into consideration the varied backgrounds of the members and their contradictory simultaneous roles, one could assume that the organization could not be very effective, and it put its members ethically and intellectually in a difficult position.

An important source of power to the Consultative Committee was the formal and legitimate authority which it had, simply because it was appointed by the National Board of Health - to perform an important task. As the design suggested, the Consultative Committee kept its authority in the project. The Nursing Programme was dependent on the environment for the satisfaction of its needs. For that reason the authority of the Consultative Committee as such was important. It may be that this formal authority, the mere existence of it, was the major support it gave to the Nursing Programme. That kind of authority was also imperative in regard to the health centres and hospitals and their willingness to participate.

Based on the documents originating from the implementation phase, it is not possible to say what kind of influence was exerted in selecting the agenda items. The minutes of the Consultative Committee and the Project Group suggested that members of the steering system exercised control over the decision process and identifying issues. Typical of the decision process was that important matters were ignored in one way or another, and significant decisions were avoided. Significance refers here to decisions which would have promoted the achievement of the ultimate purpose of the Nursing Programme. This was indicative of the unsolved opposite views (present in the steering system) in regard to the nature of nursing and its administrative position. Various parties involved were free to promote their own views in the decision-making process. In contrast to the organizational behaviour of the members of the steering system, nurses in the Participating Centres seemed to respect the purpose of the Programme. It was evident that the material presented by the participants of the Programme for decision-making reflected their commitment to the project.

With regard to control of knowledge and information, it could be that the Centre of the Nursing Programme together with the Nursing Research Institute were the ones which controlled information and knowledge imperative to the progress of the Programme. Through its information delivery activities, that knowledge was meant to be shared with the participants. Due to the international nature of the European Programme, the knowledge and information were shared by the profession of nursing internationally. Based on the evidence of the progress reports, that information had shaped the manner in which nursing and its function were perceived by the participants. However, the knowledge and information - available but not assimilated without special efforts - did

not have the same impact on the manner in which the Consultative Committee reacted to nursing matters.

For the Nursing Programme, various kinds of resources were necessary (time, physical environment, reference material, personnel and money). It has been indicated previously that the location of the Programme at the National Board of Health turned out to bring considerable resources to it. When the national Programme level was concerned, money was the primary resource. As was noted earlier, securing resources for the implementation of the Programme was a special mandate of the Consultative Committee. Certainly, development efforts in nursing had to compete for scarce resources. For that reason, in principle the securing of resources was essential to successful operations of the Programme. What was written in the minutes of that Committee does not reveal any activities for better financing. Some light can be shed on this matter by comparing the Consultative Committee with the Coordinating Committee which already had created the resource niche for the Programme. As a matter of fact, the Coordinating Committee generated in principle all the resources the Programme ever possessed, though annually the application for funds had to be presented to the National Board of Health. One possible interpretation is that the Committee was satisfied with the level of functioning regardless of the earlier plans and gradual expansion of the Programme. In other words, the Consultative Committee literally controlled the scarce resources. Metaphorically, the Consultative Committee was a paradigm of an organization as a political system.

Unlike the other organizational elements, the Project Group seemed to contain several equally characteristic metaphors in its organizational image. The machine metaphor was shaping its image. It was its product the Concrete Objectives of the Nursing Programme which linked the Group with a machine-like organization. It was a hard procedure to ask all Participating Centres to sign the expected outcomes of a particular centre. Psychologically, the participants were thus bound to promote the Programme. As mentioned earlier in this text, the document concerned included objectives and specific contents of the sub-programmes. This type of action indicated the belief that people can be made to follow the plan. It could be argued that the production of such a target document was a necessary measure under the circumstances where nurses could not afford to fail in their joint effort. Interestingly enough, the Project Group itself was

not able to reach its own targets. In the minutes no concern was expressed about that fact. Many of its tasks would have required policy formulations, which would have been dependent on intelligent and creative actions of the organization. In this area the Project Group seemed to have special difficulties, and therefore, the brain metaphor does not help in understanding this organizational element.

The organic metaphor is also helpful for the understanding of this organizational level. The Project Group was subordinate to the Consultative Committee and did not have autonomous relationship with the environment. Yet, it was aware of the position of nursing in the society and for instance by acknowledging the importance of the professional language, it made an attempt to affect the environment. The Group recognized the organizational needs of the participants and shared the task of providing consultation. By making their expertise available, the members of the Group not only through consultation but also through educational channels interacted with the participants and thus provided considerable support to the Participating Centres.

There were three organs at this level of the organization; namely the Consultative Committee, The Project Group, and the Centre of the Nursing Programme, which were providing support to those implementing the Programme. Having in its membership Contact Persons, government nurses, and nurse scientists, the Project Group exhibited wide expertise. It was natural to expect that the individual members of this Group along with the Centre of the Programme provided major support to the Nursing Programme. The Consultative Committee had declared that it would deal with broad policy issues, secure resources, and on a general level direct and monitor the effort. It is difficult to capture the nature of support this Committee provided to the Programme and to nursing. The Committee as a collective had little interest in the subject matter. It can be contended on the basis of its minutes that it did not commit itself to nursing though it supervised the Programme. Indeed, this Committee neglected the need to develop nursing language, ignored the significance of educational issues and prevented - helped by the Project Group - the mobilization of the public opinion to support nursing.

The vast area of health services which the Nursing Programme covered was very seldom referred to, and the various achievements of nurses were not reflected in the deliberations of the Consultative Committee. Through all the written progress reports, publications and the follow-up seminars, the Committee at least had the opportunity to learn what occurred in the Programme and in nursing. Therefore, the directing and monitoring were possible to accomplish. The resource niche was created by its predecessor, the Coordinating Committee. It is obvious that some of the individual members of the Committee, by using their own means, contributed in a meaningful way to the well-being of the organization. Based on the documents, however, it could be equally well inferred that the Committee secured the financing of the Programme or that by its politics it assured that only very minor financial resources were available to the Programme. Furthermore, it is difficult to identify supportive measures as such in the actions of the Consultative Committee. In a way it lived its own life remote from the aspirations and achievements of the participants. It is contended that the Consultative Committee kept the Nursing Programme going but it had separated itself from the purpose of the national and international project in nursing.

4.3.5. Responsible groups in the Participating Centres

In this section, the focus will move to the Participating Centres. As indicated in Table 4.1., responsible groups in those Centres formed the third organizational level in the implementation phase. In order to describe the organization as it operated in the Participating Centres, the information was extracted from the final reports written by nurses. In the preliminary outline for the final reports a suggestion was made that information about the way work was organized should be included in the reports. There were four typical research reports which did not include this type of information. The description of this level of the organization is based on 37 final reports. The texts on which the following account is based were not extensive and generally did not include detailed explanations of principles, procedures or division of labour. Rather, they simply explained who did the work. Three categories of organization emerged from the data, each included about one third of the Participating Centres.

In the first category, formal organization was established for the Nursing Programme, a steering group and a project group. The steering group was often the regular multiprofessional governing body of the institution or a special group appointed for the Nursing Programme; if the tasks of that group were mentioned, they were similar to those of the Consultative Committee. The project group was typically composed of nurse managers, head nurses and nurse representatives from the clinical areas, or teachers in nursing schools. Joint planning and preparatory work was done in this group, and then implemented in direct patient care or in teaching.

In the second category, the implementation of the Programme was administratively even more a part of the management system than it was in the previous category. According to this organizational model, nurses who evaluated, reoriented, and further developed their own practice, cooperated closely with their nurse manager. In these instances, the nurse manager was a member of a team or she was given a leadership role in the team.

The last category included more than one third of the organizations, and they were formed exclusively by the practitioners themselves. These units of nurses were using the support provided by the Nursing Programme locally and nationally but mainly they themselves bore the burden of reorienting their own practice. These groups were also supported by their own nurse managers. It is possible that (e.g. in a big health centre) a formal organization for the Nursing Programme was established, but it was not mentioned by nurses describing their work.

Judging from the reports, various specialists, such as psychologists, physiotherapists, and social workers, were consulted if they were not a part of the organization. The reports provided information also about the resources made available to the participants and their groups. Additional resources for the local projects were obtained in some cases: two university hospitals had appointed a nurse researcher, some minor resources were made available e.g. for the base line study and for the final reporting. As a part of the educational or administrative budgets, costs for participation in local

and national education were included. This was a considerable and significant resource in support of the Nursing Programme. The prevalent pattern was that the reorientation of nursing services and nursing education was made without any additional resources as an integral part of everyday practice. The following discussion is based, not only on the organizational information, but on content information as well. That part of the final reports is presented in the following section of this chapter.

Discussion As was described above, nurses participated in the Nursing Programme in slightly different organizational settings. Yet, common features in all settings were, that those involved were the ones whose practice was reoriented, and research and development in nursing was in the hands of nurses themselves. Thus, the vital human resource in terms of the Nursing Programme was formed in the practice and education settings, more specifically, in all categories of nurses. Flexibility and creativity were required to bring about change in practice and education. Flexibility was necessary because the development projects were an extra element in the workload of teachers, managers, and other nurses. Creativity was a promoter of the reorientation and theory implementation.

The machine metaphor does not help to understand the local and clinical level of the organization. This level (i.e. responsible groups in the Participating Centres) in its actual work aimed at getting rid of the fragmented and routinized approach and decision-making, which according to Simon (1976) were the solutions when the limits of human rationality were encountered. A broadly based holistic approach to people with needs for nursing care, was the advocated mode of nursing. Some characteristics of an organic organization were identified in that nurses made an attempt to employ the expert resources in their environments.

This level of organization exhibited the brain metaphor more clearly than the two other levels in the implementation phase. It was different from organizations where at the upper part of the hierarchy significant information-processing and decision-making takes place and routine actions are the obligation at the bottom of the hierarchy (cf. Figure 4.1.). The demanding information-processing and learning occurred at the bottom level of the hierarchy. Support to this level of the organization was nothing but

acknowledging that intelligence and releasing it. The creative capacity was dispersed to all peripheral parts of the organization. There was no brainlike centralized organ to do the thinking for the Nursing Programme. It can be exemplified by an attempt to formulate policy concerning the nursing process and the guidelines for the development of principles as a joint effort by the participants. In comparison, the office of the Consultative Committee did not exhibit innovative and creative capacities in favour of the Nursing Programme it was directing and monitoring.

This level of organization exhibited a considerable capacity for learning. The professional leadership of the Nursing Programme was not in a position to advise in advance what precisely were the procedures required in a development project. In this respect the organization of the supervision of research projects was an easier task. To a significant extent, learning how to establish and implement development projects was left to the local groups together with their leaders and supervisors. Learning capacity was required also for finding and absorbing the new knowledge on which changes in health services and the consequent accountability were to be built. Even skills in information processing were put to use differently than before, due to the fact that the nursing process added much clinical information. A spirit of innovation was evident. The groups devised new strategies, tested them and reformed their approach on the basis of the results. These groups had a capacity to function as a holographic organization, though the process was not always painless.

There was no indication in the final reports that the efforts of the Consultative Committee to secure resources for the Nursing Programme had had a recognizable impact at the local and clinical level. The Programme was implemented as a part of everyday practice and work in the schools. There are two possible explanations for the situation. It was an explicit policy adopted for the Nursing Programme to avoid separate organizations and to integrate development and investigative activities in normal functioning. Though the policy most probably was created to promote the long-term effects of the Nursing Programme, it may have contributed to a situation where too scarce resources were provided for nurses. The other explanation is that there was a desire in the environment to control the development in nursing by manipulating resources. Only at the beginning of the Programme, the Consultative Committee made an effort to monitor the resources at the local and clinical level.

4.4. Nursing in the Participating Centres

4.4.1. Introduction

This section 4.4. includes the presentation and analysis of data from the second study setting which was termed 'nursing in the Participating Centres'. The Programme will be described from the perspective of the participants and their clients and patients. As previously indicated as a part of the research strategy, conceptual framework of nursing, and structure, process, outcome approaches (Donabedian, 1966) will be used in this analysis. There are three main sub-sections. First, based on the accounts written by the Contact Persons, the nature of nursing and its preconditions are presented and analysed. This part of the text represents structural outcomes. Secondly, the use of the nursing process by the participants, and the core content of the final reports are discussed as process outcomes. Finally, the clients' and patients' views are presented. The quotations (translated from Finnish) originate from the data, i.e. from the accounts and from the final reports.

4.4.2. Accounts: the structural outcomes

Discussion in this section is based on the accounts written by the Contact Persons in the Participating Centres (N=17). These Contact Persons had some characteristics in common. They were all nurses who held senior positions in the health centres or hospitals. The Contact Persons were administratively accountable for the progress of the Nursing Programme on the local level but they were also privileged in the sense that they had easier access to courses and meetings organized to support and develop the Programme than the rest of the nurses, who also had active roles in the Programme implementation in clinical settings. In other words, these Contact Persons were the

best informed people familiar with the overall Nursing Programme as well as with the Programme implementation in their respective centres. Finally, these same nurses were very much involved in the discussion and debate whereby a shared understanding about nursing as a discipline and profession was searched for. Therefore, the Contact Persons were asked to provide an expert account on matters essential in nursing. Five of the Contact Persons chose not to write an account.

Conceptually, the content of this section represents the structural element in the evaluation of nursing services. This discussion includes information about the preconditions of nursing of a high quality as experienced by the writers when the Nursing Programme was in action, and also some future projections. Together, they represent structural outcomes of the Programme.

The five themes covered in the accounts were nursing practice, education, leadership, research and development, and the future of nursing. In the instruction for writing the accounts, certain suggestions were made as to the possible aspects the writer might consider in her account. Most Contact Persons followed the suggestions. The accounts were so structured that as a result of the data collection procedure, the data was already located in those five broad categories mentioned above. Content analysis of the separate five themes was continued by identifying subject matter categories as they emerged from the texts. Quotations included in the text indicate the content and the tone of the messages in the accounts. In the instruction for writing the accounts, it was stated that the analysis will be presented anonymously.

Nursing practice In the accounts, the core of nursing and its function in society had the following key determinants. Nursing is human service to individuals, groups and society, and it is offered at highest possible level of expertise. It is a response to health and illness related needs of people in all age-groups. It serves people from birth to death, and it covers all the phases of the health care continuum from health promotion and maintenance to the care of the terminally ill and the dying. Inherently, nursing is the same regardless of the medical speciality attached to which nursing is practiced. The next quotation was one of the goal-statements.

The goal of nursing is to foster wholeness = health in a person so that he or she could lead a normal and humane existence in all phases of life, and at the same time have a positive impact on the life of other people.

The following description of nursing, from a health centre, is an example of the way in which nursing was portrayed:

Nursing is based on nursing knowledge, nursing skills, and nursing ethics. Characteristic qualities of it are helping, supporting, caring, listening, and being present. The person as a totality and his or her experiences are observed in the process whereby nursing is fulfilling its function, that of meeting - within certain boundaries - the basic human needs of persons, families and society at large. In principle, a person is perceived to be active and responsible for his or her own care, yet, both activity and responsibility are dependent on circumstances encountered by the person. Nursing is delivered in a manner which enables the person, the family and the society to become independent as rapidly as possible. The goal of nursing is to maintain the patient's and client's health, to prevent illness, to sustain recovery, if required to help to accept the illness and to adapt to the changes caused by illness and injury, and to support the dying and his or her relatives.

Two elements are included in nursing, the physician-initiated care, and care based on independent nursing decisions. Nursing personnel is working together with other health professionals, and the relatives of the patients and clients. It also brings nursing expertise to working parties and to society at large, and is thereby exercising influence.

In addition to the characteristics presented above, supplementary qualities were mentioned. The acceptance of the challenge presented by the topical social and health problems (such as increase of the elderly population, rootlessness of the youth, or unemployment); concern for the environment and living conditions of people; participation in community planning; and becoming actively involved in the health planning, and organization and evaluation of services were also included in the function of nursing. It was believed that the importance of nursing would increase in the future due to the fact that medicine was approaching its financial and technical

limits. Apart from the general statements of the significance of nursing, there were statements related to particular nursing situations. The following quotations exemplify those specific statements.

In the era of abundant specialized services, the community nurse aims at treating the individual and the family in a holistic manner, in other words, by observing the individual as a physiological, mental and social being.

It is the task of nursing to influence the decision-making in society in such a way that home care of people suffering from long-term illnesses as well as of disabled persons will be accepted and made possible.

On the one hand, the accounts convey a firm belief in the significance of nursing in society, but on the other hand, awareness of restrictions is clearly indicated. There are two examples of it.

The level of education, the subordinate status of woman and the female submissive attitude are reflected in the legislation according to which the nurse is a hand-maiden of the doctor, and that is the kind of position a nurse is commonly believed to hold.

The perception of the mission of nursing of the surrounding society has an impact on the manner in which nursing is offered, and on our opportunities to care for people.

The nature of nursing as practiced and as seen in the future, included the clarification of the principles underlying nursing. Making those principles explicit by formulating them in writing had been a beneficial exercise in the Nursing Programme. The significance of those principles was expressed e.g. in the following way:

Based on my experience, the most significant outcome has been that the philosophical issues underlying nursing have become clear.

Helping people, who have health and illness related needs, by means of basic principles, I consider crucial in nursing's mission.

According to the accounts, discussion about the concept of man has been a part of the explorations. The accounts did not give complete lists of adopted principles but some examples. Principles related to a person were individuality, self-care and self-determination; a principle related to a broader social construct was family-centredness and principles related to nursing services were humanity, holism, patient-centredness, rehabilitative mode, and continuity of care.

As a result of research and development, distinct features were observed in the prevailing nursing practice. The language of the accounts gave the impression that nursing was perceived to be in a dynamic stage. There seemed to be development from task-oriented nursing to patient-centered nursing. The best indication of that development was the growing interest in primary nursing. However, team work continued to be a pattern of nursing as well, and the accounts revealed that nursing was still practiced by performing a series of tasks on certain wards or in stressful situations. In other words, the earlier prevalent functional nursing was resistant to change. The quality of patient-nurse interaction (or client-nurse interaction) had improved, and this element of nursing was appreciated by nurses themselves more than before. Special efforts were made to provide time for human interaction. This seemingly laid the ground for guidance and patient teaching towards self-care. It also facilitated cooperation with the families and relatives of the patients and clients. The following are some examples of those observations:

The role of the nurse has changed from a passive for-the-patient-doer and performer of activities, to a person who is guiding, supporting and listening.

Matters of purely human nature, such as friendship, are emphasized in nursing as well.

Another clearly indicated dimension of change was that from an unorganized pattern to a more systematic approach in nursing. The concepts used to describe this change were: [the approach was more] need-based, holistic, goal-oriented, purposeful, and organized. Implementation of the nursing process in everyday practice exemplified this change though the comments in the accounts were not related only to this method. Because the nursing process was such an important element in the Nursing Programme, it followed that all the Participating Centres made an effort to employ that method. Indeed, the overall picture given by the accounts suggests that clear progress

was made in employing systematic nursing. The following quotation exemplifies its advanced use:

Systematic nursing has become clear to some nurses, and they are able to commit themselves to patients' needs and objectives for the entire process of care.

As the previous quotation indicates, all nurses were not considered skilful enough to employ the nursing process. Both strengths and shortcomings were reported in regard to separate phases of the nursing process. The scope of assessment was broader than before and documentation was clearly improved, whereas stating problems caused difficulties and at times there were shortcomings in planning. However, a written care plan was considered to be an important tool for the use of a team. There were indications of patient/client participation in planning and evaluation of nursing care. One of the identified reasons for shortcomings in the implementation of the nursing process was a lack of clear conceptualization of nursing. However, some positive mention was made of the use of theories in nursing practice. Similarly, the physical environment in which nursing takes place was noted. Nursing initiative and advice was listened to when old institutional environments were renovated.

As was noted earlier in this text, the Consultative Committee expressed the fear that the Nursing Programme would violate the good working relationships prevalent in the health service system. It was also noted that one of the first positive outcomes recognizable in the progress reports was improved collaboration with other health professionals. In half of the accounts there were comments about the collaboration with others. Working together with patients, clients, and their families was considered to be a pattern or working relationships were considered to have improved. One instrument for collaboration ensuring continuity of care was nurse referral whereby a nurse is informing other nurses about matters of importance in the individual patient's care. The following quotations further illustrate the views expressed about working together:

I consider it significant that people themselves are provided with the unconstrained opportunity to weigh the decision alternatives and to select the very alternatives which are pertinent in a particular individual life situation.

Different categories of health professionals show more mutual appreciation as regards the expertise and contribution of the others.

Collaboration with the home care sector and other hospitals is now considered self-evident. Already at the beginning of the hospital stay these matters are clarified.

Contact Persons observed that the professional identity among nurses had strengthened during the Nursing Programme and had brought about favourable changes in the orientation to work. In nursing personnel, there existed motivation for analysis and advancement of nursing. This positive attitude may be related to the subsequent observations by the Contact Persons, according to which there was clear evidence of interest among nurses in developing their own ability and skills in nursing through further education, supervision or independent learning. The following quotation summarizes the development:

As an outcome of the development programme there is a clear understanding of the nature, content, mission and significance of nursing among nursing personnel itself and that has resulted in strengthening of the professional identity.

In summary, the purpose of nursing in society as described in the accounts is to provide humane service to individuals, groups and society as a response to their health and illness-related needs. Included in the mission of nursing are also concerns for the environment and broader social issues. Though the significance of nursing was believed in, some constraints on its practice were recognized. Clarification of principles underpinning nursing was acknowledged. Nursing was said to be in movement towards holistic, interactive, systematic and collaborative approaches.

Nursing education During the writing of the accounts, nursing education in Finland underwent major changes. The accounts were written in-between the old system and the new one. On the whole, the accounts reflected positive attitudes towards the possibilities education has in supporting modern nursing though considerable criticism was presented of some traditional patterns in it. A few of the authors expressed the view that nursing education meets the practical requirements,

yet, the majority of the accounts contained some kind of criticism. There were four sources of criticism of basic nursing education, i.e. education leading to professional qualification. It was felt that medicine and the concomitant disease orientation, as organizing elements in nursing education, were not optimal solutions. They resulted in one form of compartmentalization, which was also manifested in the orientation to special procedures as a prevalent content of learning. As an important prerequisite for education, a reference was made to the importance of updating the knowledge of teachers about recent developments in nursing and some dissatisfaction, in this regard, was expressed. One of the suggestions made for remedy, was closer cooperation between the educational and health authorities.

The writers indicated that lack of knowledge and skills of nurses had been recognized in some areas. For instance, nurses were not familiar with the nursing concepts; their command of nursing philosophy and theories was superficial; skills in treating elderly patients humanely, skills in using the nursing process and skills required for collaboration were not satisfactory according to some of the Contact Persons. In the accounts from two university hospitals, an indirect criticism was presented by arguing that, if hospitals continue to receive 'untrained' nurses from the schools, an unbearable burden is created on in-service education.

In one of the accounts, a comprehensive description of cognitive, affective and psychomotor requirements for a professional nurse was given. It was stated that the nurse should exhibit the following characteristics or have a good command of the following areas: to understand the professional nature of nursing and commitment following from that; to possess a strong professional identity; to have a good grasp of the most important nursing theories and their practical implementation; to have command of different kinds of philosophical approaches, values and principles underlying nursing and to be able to practice accordingly; to master knowledge and skills required in human encounter; to be able to employ the nursing process; to know about measurements in nursing such as dependency scales; to possess basic medical knowledge about diseases and nursing knowledge and skills related to those diseases. One of the Contact Persons expressed her goal in nurse education to be 'a person with a wide range of interests, a person who is able to think, who is visionary and who has the capacity to develop an ethical professional identity'.

Several suggestions were made for the improvement of postbasic education. To explore and to pursue in depth studies of matters which are essential in nursing was suggested. Such matters were, for example, the theoretical foundation of nursing, nurse-patient interaction, guidance and teaching, patterns of nursing and systematic nursing including documentation. There were also suggestions which indicated efforts towards more integration. Health was offered as an integrating concept. Comments were made against compartmentalization and nursing as a major subject in the curriculum was perceived as one integrating element. Statements against sharp specialization appeared as well. Many features which were related to the expanded roles in nursing were noted, such as ability to do research and to implement development projects. Abilities to facilitate research and development, leadership and management skills and quality assurance along with supervisory skills were suggested to be included in the education at the postbasic level.

Continuing education and in-service education as a part of it were given very much the same content as basic and postbasic education had received.

Main theories, concepts of man, health and illness, basic principles, standards and criteria will require much work before they are recognized and assimilated so that they become means whereby practice is guided.

It seems to me that the challenge to in-service education is emerging from the planning of nursing care and its documentation, from the unit-based plans on nursing development, and from the refinement of patterns of cooperation.

Learning in small groups on the unit level was a preferred pattern for in-service education. Some comments were made, on the one hand, about the need to encourage nurses themselves to act as instructors; in other words, utilizing resources existing in the staff. On the other hand, the need was identified for special preparation of the in-service educators. There was one statement which indicated a need for continuing support to nurses who do not have the strength to take care of their own development; one remark suggested that to a clinical nurse - as opposed to a manager - more opportunities for continuing education should be provided. Continuing education was

perceived as a means whereby the updating of knowledge and skills can take place and it was given special importance during the period of change. There was no question about the necessity of lifelong education. However, due to lack of equity in the society, a female-dominated profession such as nursing, was said to have some shortcomings in fulfilling this modern requirement for lifelong learning and it was expressed in the following manner:

As long as it is the responsibility of the woman to take care of the elderly, children and home, she simply does not have enough time and resources for her self-development after a heavy and demanding working day.

In summary, the accounts reflected on the whole, an understanding that nursing education has qualities in support of modern nursing, but some criticism was also presented. The domination of the medical model in education was criticized. Weaknesses were identified in areas of great importance, such as command of the ethical and theoretical foundation of nursing and in interpersonal skills. Learning about research and development, quality assurance and leadership skills were attached to postbasic education and in-service education was given very much the same content. The necessity of lifelong education was acknowledged.

Leadership and management It could be stated that the starting point of nursing leadership were laws and regulations and providing services in accordance with them. However, in a majority of the accounts, nursing administration oriented from the patients or the population, or from the purpose of nursing. This was expressed by arguing that the patient is the employer, or that information about the clients and the population as a whole was necessary for identifying problems nursing will encounter. The same basic notion was expressed by considering contact with nursing's reality as a precondition for good decisions. There were also statements about human resources (i.e. nursing personnel by which nursing services are rendered). One Contact Person contended that the same qualities which characterize the approach to patients and clients applied to nursing personnel as well. In other words, nurses should be treated as individuals and by appreciating their holistic qualities.

The main goal of a nurse manager is the motivation of nursing personnel so that patients receive the best possible care.

The position of a nurse manager seemed to be problematic in several ways. Lack of autonomy and equity when compared with the other members of the executive group was evident. It could be that the position of a nurse manager was recognized in private discussions but not in the official decision-making situation. Matters of importance to nursing could be dealt with in the executive group without the presence of the nurse manager and it was concluded that because patient treatment is a joint activity, disagreement with other members of the team may cause trouble and even forbid research and development activities. This prevalent situation was illustrated also by noting that the scope of practice of a nurse manager alternated due to the working relationship with the respective physician.

The position of a nurse manager as stated in the official regulations and partly in actuality as well is demoralizingly subordinate.

Regrettably, all nurse leaders do not recognize what takes place in reality, or because of their own comfort, are afraid and unable to accept accountability: they prefer the role of a small secretary who deals with trivial matters.

A nurse manager has duties and obligations but there is a lack of authority and recognition.

Quite general was the expectation that the position of a nurse manager should be recognized officially. One of the Contact Persons noted what is required in addition to the rules:

No reform in the regulations will correct the situation if we ourselves do not possess strength and courage, and be worthy of our position.

But even in their conflict situations many nurse managers saw possibilities for self-regulation. By being diplomatic, a nurse manager might redeem his or her position. The gender issue added to the difficulties and led a female manager to make sure, before the decision-making, that her agenda item had a male supporter. Presenting her opinion was interpreted as lack of collaborative skills. Collaboration meant that nursing personnel were preparing or performing tasks given by others, most often by

the physicians. In a demanding decision-making situation, a nurse manager was seen as a power-eager intriguer if she demonstrated accountability and made the decision.

An entirely different kind of problem was also identified in the accounts. This problem was an internal one and concerned the priority areas in the role of a nurse manager. It was considered to be a dilemma that much of the resources of nurse managers were used on trivia, in other words, on management routines, instead of employing them for the immediate benefit of nursing. The trend of the development seemed to be that in the management role, the emphasis was on nursing leadership and nursing expertise. This view was expressed, for instance, in the following manner:

One observes in practice that administrative and educational methods are ... without an anchor if nurses holding different kind of positions do not possess expertise in nursing.

The development of the role of a nurse manager towards nursing leadership and nursing expertise has clearly emerged during the Nursing Programme.

There were a few favourable comments about the preparation of nurse managers. It was however also contended, that among nurse managers there was a lack of internal precondition for leadership, i.e., lack of self-confidence. There was also a lack of external precondition, i.e., a lack of authority. One Contact Person argued that: 'nurse leaders desperately need up-to-date knowledge about nursing and exchange of views'.

If mention was made about the key roles in nursing, head nurses and nurse managers were given key roles in the development. The leadership style, or some aspects of it, emerged from some of the accounts. Contact Persons used the language which conveyed their attitude towards being a fellow worker of the staff nurses, and one of them saw the opportunity to establish teams which could exhibit full self-governance. The following quotation exemplifies the discussion.

A participative leadership which seeks the appropriate balance between a clear goal-directedness and a creative process-like approach, would be an ideal pattern of performance of a leader.

In summary, according to the accounts, nursing administration generally oriented from the purpose of nursing, and familiarity with the reality was considered a precondition for decision-making. The accounts clearly indicated the lack of autonomy of nurse managers, but also the role of diplomacy in everyday life to create some self-regulation. There was some uncertainty in finding balance in the role of a manager; emphasis was given to leadership and nursing expertise instead of more conventional management routines. The significance of participative leadership was noted.

Research and development In the accounts, on the whole, research and/or development in nursing were given great importance. This pronouncement was made from the perspective of the practice settings and in relation to the functions of these practice settings. 'One should always have something on the agenda' was a statement reflecting the positive attitude. Research and development was not an obligation given exclusively to the universities or university hospitals. It was considered as a positive sign that nurse researchers were accepted in the health institutions. There were three broad categories of arguments in support of the assertion that research and development in nursing are imperative:

1. Research and development facilitate the production of needs-based high quality and cost-effective services for the benefit of patients and clients. Examples given were: research and development provides knowledge for nursing practice; it feeds information to planning and resource utilization; it adds to the safety of nursing care and research may draw attention to matters requiring improvement.
2. Participation in research and development creates in general positive attitudes which in their turn facilitate further development. Examples given of this category were: that heightened motivation exists among nursing personnel for their own practice and for learning novel things; that awareness of one's own resources and possibilities gives rise to an atmosphere for creative ideas; that more analytic and deeper conceptualization of nursing is apparent; increase in professional interest is evident; a critical approach to nursing as practiced has developed; need for support, education and supervision has increased; needs have emerged to have an impact on matters concerning nursing; participation adds to the international interaction.

3. Nursing as such receives appreciation when supported by research and development. Examples given were: research describes and explains nursing and it facilitates theory development; it is a means for making nursing and its education scientific; 'the image of a female-dominated profession can be sharpened through research which shows the needs and outcomes in nursing'.

The description given above about the significance of research and development in nursing showed a general positive attitude. Yet, the picture given by the accounts as regards methodological and financial resources, especially for research, showed that on many occasions there was an identifiable lack of resources. Half of the centres reported that they were able to accomplish development projects with the skills existing within the staff. In half of the centres it had been recognized a lack of research skills though some institutions had been able to develop the skills amongst their staff or outside resources were easily available. The majority of the centres was able to obtain financial resources, whereas some foresaw problems in financing. The source of finance was mainly the federation of communes governing the respective centre. The prevalent attitude among these decision-making bodies seems to have been positive towards research and development in nursing. The prevailing attitude towards research and development among nurses was also positive. The following quotations exemplify that attitude:

...nationally and regionally we could agree on common goals and from time to time we could share information about our achievements.

...let us have the habit of continuous development which is externally supported and evaluated.

In summary, research and development were considered imperative to nursing. It was believed that research and development will facilitate the production of quality nursing, bring recognition to nursing, and by creating a distinct atmosphere further advancement of nursing. Some lack of research skills was noted. On the whole, hospitals and health centres were able to obtain financial resources for research and development.

Nursing in the future Some challenges in regard to clients' situations and patients' needs were presented in this connection. It was argued that nursing was offered to people who actively sought this kind of service but no effort was made to find those who were most in need of nursing services. The same author noted that the location of houses built for the elderly had isolated them from their familiar environments and among young families rootlessness and mental problems had been identified. Family-centredness was suggested as a remedy. Nursing in the future should be able to develop better self-care abilities in certain groups of patients and it should demonstrate profound interaction skills.

Future nursing education was linked with the recognition of the profession of nursing and it was believed that educational solutions would promote recognition. It was also argued, however, that educational and investigative opportunities provided to nursing in society, indicated recognition. It was believed that making education more scientific was an important move. In regard to education, mention was made of there being a need for nursing literature in Finnish. There were signs of more support to learners in hospitals. One of the Contact Persons felt that the growth of nurse leaders required supportive measures. To keep nurses up-to-date and to prevent a delay in knowledge distribution - which often happened - more close integration was suggested between educational and service needs.

The accounts clearly indicated that an autonomous position of nursing is a key to balanced development in the future.

The key factors in bringing about development in nursing research, education, and leadership are, developing academic education, including the obligation to develop nursing in the national five-year plans, and making rules and regulations of the institutions more favourable to nursing.

Similarly, the accounts suggested various types of collaboration in support of future development. Those suggestions included collaboration between educational and health authorities; collaboration between research, education, and administration; collaboration between managers, teachers, and investigators; collaboration between

teachers, managers, and nursing staff; international and local collaboration and finally, in two of the accounts a suggestion was made about uniting separate nursing organizations existing in Finland. There are two examples of the statements:

Ensuring international collaboration and follow-up of international development by giving official recognition, in order to enable us continuously to join in exploiting achievements in nursing.

Joint efforts which are goal-directed are one guarantee of bringing about balanced development.

Research was considered to be an essential element in the future development. It contributes to theoretical and scientific development in the discipline of nursing. More research posts were perceived important e.g. in central hospitals and it was pointed out that nursing research and researchers required more support.

In summary, factors which could contribute to a balanced development in nursing were noted. Educational arrangements should bring recognition to nursing. A varied range of collaboration was given importance as promoter of a positive development, and research was perceived as essential. Gaining autonomy for nursing was said to be the key for a balanced development in nursing.

Discussion The accounts have been summarized in the text as if the writing would represent the hearing according to the adversary evaluation model. All possible viewpoints were recorded as a testimony of witnesses. It is believed that this would have been the content of discussions if, for instance, the government would have decided to consult 'this noteworthy pool of experts in nursing' after years of work with the innovative Programme. It is assumed that on the whole, the accounts reflected accurately the level of understanding reached by the time of the Programme completion. The accounts of the Contact Persons demonstrated positive attitudes as far as the future of nursing was concerned. The Contact Persons had seen favourable changes taking place in nursing; they gave their support to research and development and the criticism of education was constructive. In this connection, it is important to note that in the Nursing Programme, the driving force and the innovative party was the service field not the educational one. The discussion about the context of the

Programme gave some indication of the position of nursing in society, characteristic of which was a lack of autonomy. Some of the accounts sharply analysed the leadership position of nurse managers and also gave insight into the work of nurse managers.

By using Donabedian's structural approach and the information provided by the accounts, it may be suggested what kind of structure for nursing was built within the Nursing Programme. In terms of human resources, there was no lack of nursing personnel and there were no signs of maldistribution of nurses. As a whole, the expert accounts gave the impression that in the health service system, a well motivated and capable nursing work force was operating. This work force was believed to take an interest in further development. Yet, certain weaknesses were identified in that human resource. Among them were that all nurses did not have the necessary command of the nursing process, that all nurses did not possess an extent of self-governance which would have guaranteed continuous individual development and that some newly graduated nurses had some deficiency of knowledge. The continuum functional nursing - team nursing - primary nursing represented the manner in which human resources were organized. The expert accounts clearly indicated that primary nursing was the direction of the development, but they also showed that progress towards primary nursing will have its own pace.

Physical resources were not widely discussed in the accounts. Unlike in medicine, technology (i.e. equipments, tools, and instruments) is not so essential in nursing. This statement can be made though, it is true that there is useful technology in the use of nursing as well. Discussions of the Contact Persons referred exclusively to the environments where nursing care was rendered, e.g. to the delivery room, the psychiatric ward or the rehabilitative environment for the hospitalized elderly. The interest in this matter was a positive feature of the structure.

Financial resources were dealt with in relation to further education, and research and development projects. Finance did not seem to be a restrictive factor though - as is the case with every field of interest - nursing had to compete with others for money and though some nurse managers had better experiences than some others.

Social and cultural factors as structural elements were not discussed in the accounts. What could have been considered to be social and cultural factors in this connection were the established health culture of the country and the prevailing social policy. The Primary Health Care Act passed in 1972 could be considered as an example of the health culture and the existence of the infrastructure for the delivery of services, from primary to tertiary level, was a favourable social factor.

The leadership theme invited comments by the nurse managers which clearly portrayed the position of nursing in the society. The administrative practices uncovered by the accounts suggested two things. Managing nursing services was not an easy task for a nurse leader. She encountered difficulties which in principle should not have existed, as the provision of health services is a labour-intensive area and nursing personnel the largest single human resource. The picture given by the accounts is very similar to those given by several nurse historians (Fitzpatrick, 1983; Palmer, 1983). But on the other hand, nurse managers had developed their own strategies, called diplomacy, in order to be able to do their job. Under such circumstances the Nursing Programme was carried out.

The structure (which the accounts represent in the analysis) included one restrictive feature. There was one dilemma or issue which emerged from the expert accounts. On the one hand, nurse managers were positive and true advocates of nursing personnel; it could be argued that the leadership style exhibited qualities which are essential in support of primary nursing. On the other hand, they removed themselves from the rest of the nurses. The prevalent conceptualization in the manifest content of the accounts was not 'we together' or 'working together' though self-governance on the unit level was once mentioned. It was stated clearly that the root of nursing was the direct care to patients, clients, families and the community at large. Logically, it would follow from that statement that a clinical nurse, (this expression refers both to nurses working in institutions and nurses in the community in direct contact with their patients and clients), has a key role in nursing, and that he or she has the primary right to know and to understand matters into which their managers try to guide them. However, those things were not suggested. Even the data collection for this study partly exemplified the same key issue, in other words, instead of nurse clinicians, nurse

managers were approached. It is an established tradition that those who practice nursing are not obvious representatives of nursing. If the ideas 'a nurse has a key role' and 'a nurse has the primary right to know and to understand' were followed, it would change the educational system and that would have a profound impact on the way nursing is organized. It could be that this will be the way forward for the profession of nursing. A small thought experiment along these lines is thought-provoking. The question of what would follow if nurses began to believe that it is both a privilege and a source of pride to work closely with people should be explored. That contact and the opportunities it provides have not been appreciated. Obviously, if clarification is sought from the viewpoint of the recipients of nursing - as the accounts suggested - it could be argued that the resources should be where nursing is offered.

4.4.3. The process outcomes

This section presents two perspectives of the Nursing Programme. First, the results of a test use of the nursing process, i.e. the analysis of the Nursing Care Plans, are presented. These results show the level of mastering this method in a test situation. The other part of this section builds on the final reports from the Participating Centres which provide a much wider spectrum of ideas and outcomes than the previous one.

4.4.3.1. Use of the nursing process: the process outcomes

The role of the nursing process in the Nursing Programme has been explained earlier in this text. The demonstration of the utilization of that method is dealt with in this section. The instruction given to the participants advised every participating unit to do assessment, planning, and the consequent documentation in the same manner in which these functions were performed in everyday practice. There were typical ways of organizing this demonstration which had the character of a pencil-and-paper test. A nurse prepared the nursing care plan alone, it was prepared by first level nurses as a group, or it was prepared in a heterogenous group, i.e. in a conventional nursing team.

Six different cases were presented in writing representing patients and clients. Those cases were: a school boy, a woman in hospital for delivery, a psychiatric inpatient, a patient in the hospital for mastectomy, a patient with paralysis, and an elderly person in home care. The columns in the nursing care plan were: (1) assessment data, (2) identified needs for nursing care, (3) objectives for nursing care, (4) nursing interventions, (5) implementation of the plan, and (6) the outcome compared to objectives. The intention of this demonstration was not to evaluate the accuracy of the assessment or the repertoire of nursing interventions per se. The main purpose was to find out how systematic the use of the nursing process was. For that purpose the following preset criteria were used:

- the logic of clinical reasoning;
- patient or client -centered objectives stated;
- extent to which the intervention suggested belongs to the domain of nursing;
- extent to which the evaluation is expressed as patient or client outcome in relation to the objectives;
- nurses' ability to identify needs or problems.

The judgment about the logic of the reasoning throughout a particular nursing care plan was based on the manifest fact that a nurse or a nursing team had systematically followed the identified need or problem as the plan was developed. The demonstration data seemed to suggest that problem identification took place more often than need identification, but there was also a mixed use of needs and problems within one nursing care plan. There were few singular cases where the handling of clinical information was not logical. One of the key points in employing the nursing process was the attempt to state patient or client -centered objectives instead of considering the performance of nursing interventions as an objective. With regard to this criterion, about 40% of the plans included patient or client -centered objectives and the rest of them exhibited nurse-centered objectives or a mixture of both.

In conceptualizing nursing, the medical model had been prevalent and, as a result of that, mainly medical interventions or medically initiated interventions were included in the nursing documents. That observation gave birth to the criterion of the nature of the

interventions. In analysing the test documents one additional category was created; namely, coordination of the treatment or health care. In a few cases, medical intervention was presented in a nursing care plan as a nursing intervention or, a mixture of medical and nursing strategies was suggested. Nursing interventions and coordination were the prevalent modes. Evaluation of patient or client outcomes was known to be difficult in a situation where no true actions existed, i.e. in a test situation without real patients or clients. The documents, however, suggested that the evaluation was clearly focused on the patient and client outcomes.

In summary, the test use of the nursing process demonstrated that this method was employed in a manner which exhibited internal logic; nurses were beginning to use the appropriate expression for patient and client -centered objectives, medical interventions did not dominate but coordination was an important action, and evaluation was focused on patient and client outcomes.

Discussion By employing Donabedian's process evaluation as a framework, the following observations can be made. The use of the nursing process as such exemplified the application of available knowledge and method which were believed to be beneficial for the reorientation of nursing. The nursing care plans included, as assessment data and as identified needs or problems, the specification of the individual's health situation. The objectives and methods were recoded into the plans but they did not contain information about the reasoning and justification of the choice of needs or problems, objectives or methods. This analysis thus ultimately covers only a small part of the process present in actual nursing. The coordinating function of nursing was quite evident in the plans. Before the Nursing Programme, based on the analysis of the clinical records the conclusion was made that: '...nursing equals with performing tasks and documenting those tasks' (Krause, 1984, p 84). In the test situation, the clinical approach was more comprehensive.

4.4.3.2. Final reports: the process outcomes

4.4.3.2.1. Introduction

This section is based on the unedited final reports (N=41) of the Participating Centres. The authors of the reports were nurse participants, except in two cases where nursing colleagues from the universities were involved in the sub-programmes and contributed to writing up the projects. There were altogether thirty eight publications in the series of the Nursing Research and Development Programme and seventeen of them were other than the final reports. In the present study, the content of the reports is presented by utilizing the four metaparadigm concepts as organizers:

1. concept of 'man' along with values clarification drawn from that concept and leading to the identified principles; this sub-section is called the ethical foundation of nursing;
2. concept of 'health';
3. concept of 'environment'; and
4. concept of 'nursing action' which includes (a) the concerns, problems or weaknesses identified in the situations of patients and clients, in nursing practice, or in nursing education, which prompted the sub-programmes; (b) conceptual frameworks for nursing or nursing theories guiding the practice; and (c) nursing interventions along with patterns of nursing and collaboration in nursing.

In this chapter, health is discussed before environment.

4.4.3.2.2. Ethical foundation of nursing

4.4.3.2.2.1. The idea or concept of man

Exploration and clarification of the concept of man took place in the Nursing Programme and was influenced by the contemporary national discussion on ethical issues in regard to health services. That wider discussion was reflected in the nursing community which recognized and discussed the four ideas of a person, those of humanistic, naturalistic, Marxist, and Christian ideas of man. The humanistic idea of man is emphasizing the spiritual nature of a person, and his or her uniqueness and freedom of action. Within the naturalistic framework, man is seen as an organism which is following natural laws and there is a great similarity between a human being and the rest of the organic or living nature. According to the Marxist view, a person is first of all a social creature. The Christian idea of man conveys the notion of a person as a picture of divinity (Lindqvist, 1978a; 1978b).

According to the writings of nurses, the major concern and focus of nursing is man and his or her well-being and furthermore, nursing is practiced in human interaction. The idea of man is thus fundamental to nursing and it is a framework for all goals of nursing and for nursing actions. According to some nurses, all the four ideas of a person were present in Finnish society. However, the humanistic idea of man was considered to be the most essential as a basis of practical reasoning in nursing. Reference was also made to the naturalistic idea of man which was seen to be prevalent in medicine and which therefore had an impact on nursing as well.

The humanistic idea of a person was characterized by the following qualities: a person is self-regulatory, adaptive, aware, goal-directed and capable of learning. A human being differs from the other creatures by his/her consciousness, reason, language, free will, creativity and culture. The following quotation is an example which shows how the humanistic and naturalistic ideas of man were perceived within the nursing domain.

A person is more than a sum of his parts (e.g. a holistic view). A person is a bio-psycho-social totality. Any change in one of the three areas, will have an impact on the others. On one hand, the physiological and behavioural processes of man, who is a bio-psycho-social being, are based on sciences and are systematic and predictable and on the other hand they alternate due to the uniqueness of man and the environment. Inherent in human life are the phases of growth and development, as a person is aiming at maturity and personal integration. There is the opportunity for growth throughout the human life. Other human beings are needed in the phases of growth and development. A person has a freedom of choice and therefore is responsible for his deeds. A person is also responsible for his fellowmen. Every human being has potential for change. A human being has an impact on his environment, but he also adapts his reactions according to his environment. (Report from a university central hospital, no. 31, appendix 11, pp 1-2)

In principle, the basic values as documented by nurses and the principles for nursing were based on the idea of man. In the following sub-section the values and principles are discussed.

4.4.3.2.2.2. Principles underlying nursing

A topic explored as part of the Nursing Programme were the principles which along with the concept of 'man' formed the ethical foundation of nursing. This topic was very briefly introduced at the beginning of the Nursing Programme by suggesting that the participants clarify and make explicit upon which kind of principles their practice was based. Seven out of the fortyone reports did not include the principles of nursing and two of those seven indicated that the principles were clarified but did not appear in the report.

Human dignity was identified to be the most significant goal value, and life and health sometimes appeared with it as basic values. Human dignity meant that a person has an unsundered right to be treated with dignity under all conditions and nurses, as well

as all other health workers, have the obligation to protect human dignity. Integrity, justice and self-determination were often considered as basic values, or those three concepts were interpreted to be principles. Integrity was characterized by unity, autonomy, and the unassailability of a person. The principle of justice was seen to be essential in situations where a person was unable to take care of himself and collective responsibility is required. Consistent treatment of people and performance the conditions of an agreement also belong to justice. Self-determination was said to require that a person has the opportunity to participate in decisions affecting his own life.

Principles of nursing practice evolved from the basic value(s). Stated principles are presented here under the four sub-headings: (1) principles related to a person as a client or patient and sometimes the principles were said to apply to nurses as well, (2) principles related to health, (3) principles related to the practice of nursing, its content and its methods and (4) principles related to the interaction and collaboration within which nurses were involved.

Principles related to a person

Uniqueness of a person

A person as a physical, mental and social totality

Opportunity for human growth and development

Freedom of choice

Adequate information about the alternatives in care

Active participation in and influence on planning and implementation of care and/or participation in decision-making

Maintenance of the person's own responsibility

Heightening of feelings of independence and self-confidence

Maintenance of independent initiative/autonomy

Self-care

Right to die with dignity

There seemed to be a clear inclination to respect the autonomy and self-determination of patients and clients and to allow them fully to participate in decisions concerning themselves.

Principles related to health

Health-centeredness

Maximization of quality of life

Mental and physical safety

Both health and overall safety were stressed as principles of nursing. The nature of illness as such was not discussed when these principles were formulated.

Principles related to nursing

Respect for the individual regardless of the nature of illness, age, gender, belief system or social status

Humane attitude and humane action for the benefit of a fellowman, empathy

Observance of the values of patients and clients

Individuality in nursing practice and patient-centeredness

Need-based approach

Comprehensiveness of nursing, covering physical, psychic and social aspects of a person and observing all the needs

Rehabilitative, preventive, activating and stimulating care

Prevention of institutionalization and dependence

Adaptation and help, support of the patient, acceptance, sincerity and pertinence

A goal-directed and systematic approach

Research-based nursing, objectivity and a scientific approach

Guidance and health education

Maintenance of essential functions of a patient such as mobility, eating, dressing, personal hygiene, health care, sleep and rest, elimination, maintaining one's personality, obtaining information, social interaction, and engaging in meaningful functioning daily

Development of nursing

Professional conduct

Based on discussion on principles in the final reports it can be concluded that nurses gave importance to various aspects of individualized nursing which would take into account the whole person and which would be practised in a systematic manner.

Principles related to interaction and collaboration

Equality in the nurse-patient/client relationship

Accountability by committing oneself to the goals

Confidentiality

Collaboration with patients, relatives, co-workers and other institutions

Establishment of good relationship between a client and a nurse; the importance of nurse-patient interaction

Family-centeredness

The ward as a therapeutic community

Continuity of care

According to the principles made explicit, nursing personnel appreciated equality, was prepared for collaboration and understood the importance of continuity of care.

For the most part, these principles were dealt with in the texts within the nursing domain and by giving examples. It can be concluded that nurses, in principle, were prepared to work according to the principles made explicit. The following quotation exemplifies the kind of meaning nurses gave to principles and to their use:

Principles of nursing direct nursing practice. Becoming familiarized with the content of the principles i.e. what they mean in actual practice, many factors are recognized which make the personnel think of their work and their own conduct. By emphasizing the principles, the quality of nursing will improve and most important, the patient feels secure and reacts with confidence. (Report from a central hospital, no. 24, p 13)

In some cases the identified principles were further elaborated and made more concrete as standards and criteria. In one instance, a full quality assurance programme was developed.

The process in which nurses involved themselves was the same as has been discussed by nurse ethicists (Davis & Aroskar, 1983; Steele & Harmon, 1983), and through which ethical principles begin to have an impact on everyday practice and to require personal commitment (Schröck, 1980). It can be noted that nurses did not concentrate on special issues requiring moral reasoning such as abortion or euthanasia, neither did they deal only with specific decision-making situations which would include ethical aspects. In the final reports moral principles were discussed as a broad basis for nursing and as having an impact on almost everything in nursing. At the same time, the scientific foundation of nursing was explored in the Participating Centres and therefore it seems to be right to argue that the final reports reflected the view expressed by Curtin: 'The end or purpose of nursing is the welfare of other human beings. This end is not a scientific end, but rather a moral end' (1979, p 2).

4.4.3.2.3. Health as presented in the reports

Compared with the discussion on principles underlying nursing, health was not so extensively dealt with by nurses and in seventeen reports brief or thorough comments about this concept appeared. As was noted previously in this section, health was also mentioned as a value or as a principle underpinning nursing. The following is a description of health as formulated by nurse teachers:

Health consists of a continuous adaptation between an individual and the environment. Adaptation is manifested in physical, mental, and social well-being. Health is a condition in which the objective signs of an illness are absent and the person himself has a sense of well-being and is socially capable of functioning. Health can also be perceived as a dynamic state of balance between a disease, the patient's experience of an illness and the social effects of an illness. Furthermore, the manner in which health is generally perceived in a particular society is always an influential factor. In nursing, illness is perceived, besides as a disease, first of all as an overall condition experienced by a person, and as social effects caused by the illness. (Report from a nursing school, no. 40, appendix 7, p 1)

The manner in which health was conceptualized was seen to have an impact on the content of nursing. On the whole, the inclusion of physical, mental and social factors was characteristic as was the notion of interaction or balance between the individual and his environment. It was stated for instance that 'as an exceptionally adaptable organism, man continuously aims at restoring the balance lost due to a change' (Report from a university central hospital, no. 31, appendix 11, p 2). Health was individual and experiential by nature. Health could be seen as a goal, as means for well-being, or as a factor in well-being. The following quotation is an example of the manner in which health was conceptualized.

Health is both a state (strength, sense of well-being) and an action for maintaining that state. The health status of a person is influenced by his lifestyle and the immediate environment which is perceived to be both physical and mental. Every person has his peculiar ways of being healthy as well as of maintaining his health. The health of a person is a dynamic and harmonious whole which is continuously reshaped by four basic factors, those of physical, mental, social, and individual development. A sense of well-being is a personal experience dependent on the personality and life situation of a given person. A perceived state which within one person is causing a sense of illness, does not cause that kind of feeling in another person. (Report from a university central hospital, no. 34, pp 6-7)

A chronically ill person could be identified as healthy provided that the symptoms of a disease were controlled, the person himself had adapted to his illness and social consequences of a particular illness had been attended. As a characteristic of health of an elderly person, coping with daily activities was mentioned. The biological state of a person, knowledge and attitudes, as well as the environment were said to have an impact on health and illness. The concept of illness as perceived by nurse authors was clearly broader than the medically diagnosed disease.

4.4.3.2.4. Environment

Environment as a nursing concept has two sides, namely, (1) environment as an everyday living environment of a person and (2) environment as those circumstances in which nursing is offered. Discussion in the previous sub-section about health already included perceptions of nurses of the importance of the environment to human health and illness. This topic has been further elaborated in a survey conducted as part of the Nursing Programme, as well as in the final reports.

In the Nursing Programme, environment was considered an essential component of nursing, and it was also a topic in a more general discussion about the environment of health services. Therefore, a survey was conducted among the participants of the Nursing Programme (N=40) through which the identification of defects in the nursing environment and suggestions for its improvement were sought. The following was perceived as an overall objective in terms of the development of the nursing environment:

The environment should support and promote meeting of the basic human needs of patients and clients; it should foster the provision of care which is geared towards health and rehabilitation; age of patients and clients, the nature of illness, and principles of nursing should have an impact on the environment. (Tolvanen & Sammalkorpi, 1984, p 9)

The defects identified by nurses were:

- restrictions of space available in rooms of patients generally was considered as a disturbing factor in terms of care and arrangements in rooms of patients did not provide privacy; on the other hand it was felt that more one- and two-bed rooms were required for individualized patient care;
- adequate space or rooms were not provided for special functions or activities (e.g. for guidance and teaching, for rehabilitative activities; for medical and administrative functions; for handling medicines; or for dining together); there were defects in existing rooms or space (e.g. bath rooms, lavatories, cupboards for equipments and materials);
- sound-proofing was poor, and
- there were defects or shortage identified of many equipments (e.g. special beds, wheel chairs); and there was a lack of audiovisual aids and literature for teaching (Tolvanen & Sammalkorpi, 1984).

In the final reports, the concept of environment included the living environment of a person, out-patient care environment and institutional environment. It was noted that nursing care can be provided directly to a patient or client, or nursing may be offered indirectly by influencing the environment. Similarly, it was noted that the environment should provide prerequisites for an individualized, comprehensive and need-based approach in nursing. The physical environment was given importance in certain connections, but it was typical to emphasize the psycho-social environment of a person as well. Several clinical or practice-related aspects of the environment were identified in the final reports and they can be categorized as relating to the quality of life of a person or to the quality of nursing care. Through an impact on the everyday environment of a person, the quality of his/her life could be improved if hospitalization was postponed or prevented. Under certain conditions which were a concern of nursing, the home (or working) environment was perceived as having a special impact on the client's health and illness and therefore on the quality of life. Social problems in the family environment of a child, such as violence, alcohol abuse, criminality or unemployment, were seen as etiological factors and they were related to prevention. For different reasons, the physical environment at home (or working environment) was significant to clients suffering from multiple sclerosis (the environment had to be such that the person was able to stay at home instead of being transferred to an institution), to clients suffering from asthma (home and working environment had to be free from irritating substances), and to the demented elderly (home environment had to remain unchanged).

Through environmental intervention, quality nursing care could be offered. There were several documented examples of this category. First, some elements of the environment were included in the assessment tool; examples of this were the residence of a patient or client, modern conveniences available in the residence, and sometimes a more spacious living environment. Second, in institutions, the environment was assessed in terms of the following aspects: the environment was expected to support self-care and independence, prevent depression and distress, provide safety and orientation, and offer aesthetic experiences. Third, under certain circumstances, the features of a psycho-social environment were given precedence; such features were the emotional environment in a delivery room, a positive environment for growth on a psychiatric ward, or a positive and friendly environment for school health services.

In summary, the 'environment' was not elaborated as a conceptual entity to the same extent as the other two concepts, namely 'man' and 'health'. It was introduced as a practical entity. The writings of nurses made it quite clear that the environment of a person, as well as the nursing environment, have significant functions in terms of well-being of people. Under some circumstances the physical environment received the main attention, however, on the whole, the psycho-social environment of a person and of nursing was given equal importance.

4.4.3.2.5. Nursing action

The final reports included often detailed and extensive discussion about nursing as it was before the Nursing Programme and how it changed - to a great extent - as a result of the Programme. In this section, the characteristics of nursing at the outset and at the completion of the project are presented. As an introduction to that presentation, the theoretical foundation as described in the final reports is discussed.

As a theoretical or conceptual framework mainly the ideas presented as an introduction to the Nursing Programme were utilized. Theoretical constructs in nursing were at the beginning dealt with in vague terms by referring to approaches. In the final reports, this area was discussed with much greater certainty. However, no efforts were made to break the conceptual structures, the intention seemed rather to be to become acquainted with the theoretical foundation of nursing and to find applications for the theories. Nurse authors conveyed the picture that a positive interest in the theoretical background of nursing was emerging.

Henderson's (1969) definition of nursing and approaches emerging from that definition, were widely utilized. In addition to that, theoretical or conceptual constructs of Roy (1980), Orem (1985), and Roper, Logan & Tierney (1985) were often presented as theoretical backgrounds for the sub-programmes. Maslow (1954) and Eriksson (1979) had stimulated thinking as well. The nursing process (Kratz,

1979; Marriner, 1983) which was mainly perceived as a method, served also as a uniting conceptual framework. Human needs as a territory of nursing as introduced by Yura and Walsh (1978) seemed to have an impact on the manner in which nursing was developed.

The rest of this section has been divided into two parts. In the first part, the concerns, problems and weaknesses identified in nursing at the outset of the Nursing Programme are summarized. These matters prompted the sub-programmes and fulfilled in so doing one of the basic principles of the Programme, that of utilizing the WHO project for solving problems identified by nurses in practice settings. In the second part, responses or solutions of nurses to those concerns and problems are presented. This section includes the description of nursing and nursing education as they were shaped by the Programme, i.e. by the joint national effort (and by simultaneous other developments in the Finnish society).

In the reports, the concept of 'man' and principles drawn from that concept, the manner in which human 'health' was conceptualized and the way 'environment' was perceived, were discussed before presentation of the novel nursing practice models or other types of outcomes. There is evidence in the final reports to suggest that clarification of the conceptual and ethical foundation of nursing had a significant impact on the development of the practice models and other outcomes. This linkage however, is not elaborated in detail in this section. Only the new understanding of the practice of nursing is presented.

4.4.3.2.5.1. Problems identified in nursing

It can be assumed that the process suggested by the Nursing Process Workbook was partly followed in identifying the foci of the sub-programmes. In other words, nursing practice was analysed according to the Nursing Programme ideas which resulted in the topics of the sub-programmes. It can be added that the base line study obviously assisted the participants in identifying weaknesses in the practice of nursing. This action taken by nurses was similar to the substantive rationality (Morgan, 1986) which

means encouragement to evaluate the appropriateness of one's own practice and to prepare oneself for changes. The concerns, problems and weaknesses which became the focuses of the sub-programmes are presented by employing the life span as an organizer as was done also in Figure 4.3. which includes the overlapping material, but only as titles. Under the underlined life phases, the titles of the sub-programmes and the problems identified as their starting points are described. This minute description is provided to point out the state of the art of and problems encountered in nursing and a brief summary will follow the descriptions.

Pregnancy and birth

Growth towards parenthood in the family expecting its first child In the maternity clinics in a health centre the emphasis had been on physical needs of individuals and consequently the mental and social needs were not adequately attended to. The same observation was made in regard to the well-being of the family. The various pressures in the society were reflected in the young families creating e.g. helplessness in parents. Frequent moving of young adults were adding to the difficulties in adapting.

Nursing in the prenatal clinic, delivery room and on the maternity ward 1) In a prenatal clinic the interview of the pregnant woman was done by an unqualified person. The interaction between the pregnant woman and the midwife was not satisfactory due to the environment or lack of personnel resources. This had reduced the amount of guidance and health education given to the clients. There were also deficiencies in the documentation due to the fact that space was not available in the records for nursing/midwifery observations.

2) In taking care of the deliveries, physical well-being was underscored at the expense of the mental and social well-being. The assessment of labour pain was difficult and consequently observing and managing pain was not sufficient and systematic. Management of delivery and its environment had become technical at the expense of the human aspects. The content of nursing was unclear and that had had an impact on the deficiencies of the personnel system. Documentation was inadequate and evaluation of interventions and the impact of care was not systematic.

3) On the maternity ward the way nursing was organized did not provide adequate support of family ties, for instance relationships between the mother and the child/children, the father and the grandparents.

Pregnancy and childhood

Family-centred nursing in a MCH clinic These were the projects integrated into an originally medical project on family doctor. That the scope of practice of a public health nurse was unclear, was the problem identified in one health centre. In another case the sub-programme received an outside impulse.

Childhood

Supporting parents of chronically ill and disabled children It was recognized that chronically ill and disabled children and their families needed help which was not available.

School age

Promoting mental health in a school environment The following questions were asked: What kind of opportunities existed to prevent mental health problems as part of the school health services? Was there unused information about the mental health of the school children? Was the mental health status at the school age known to those concerned? The existing assessment procedure was inadequate though it revealed such symptoms as behaviour disorders, headache, abdominal pain, fatigue, and lack of concentration. Public health nurses had recognized problems such as fear of the school, difficulties at school, restlessness, loneliness and violence which had been left out of the assessment procedure. To a nurse those problems were a shapeless bunch of concerns, and the school health services had been unable to change along with the changing needs.

Counselling pupils in the fifth grade on human relations and sexual behaviour At school age there were mental and social problems though the pupils were physically healthy. Problems mentioned were violence at school, abortions, attempted suicides and alcohol and drug abuse. In addition to that, a school nurse met children who had many unmet personal needs such as needs for love and affection. It was felt inappropriate to approach school children with procedure-oriented screening. Documentation was recognized as being insufficient.

Adolescence

Counselling students in upper secondary school on human relations and sexual behaviour Pupils at the age from fifteen to eighteen in the contemporary world were considered to be a multiple challenge to a public health nurse. This nurse was lacking in professional identity and professional pride. It was unclear what were the goals in school health and principles of nursing were not clarified. Evaluation was almost non-existent. Expectations concerning nursing were geared towards care of illness. A nurse felt pressures and expectations coming from various sources in the environment. Difficult ethical problems were identified and they related e.g. to abortion, use of alcohol or sexual deviation.

Nurse-patient interaction and its documentation on a psychiatric ward Motivation for care was low among the young. Resistance to care appeared in breaking of rules, escaping, stealing and aggression. On the ward level, being a community was a prevalent philosophy as opposed to individuality. The life on the ward was entirely pre-programmed. The atmosphere on the ward was unquiet and tense. Interaction between the young and the staff was problematic. The opportunity was offered to a young patient to participate in the planning session of his care, but the patient was not prepared for that. Task-orientation was prevalent. Nursing's contribution was unclear as was the leadership function in nursing. Documentation was inadequate and excluded almost entirely the emotional life of the young.

Adulthood

Supporting self-care of people of working age suffering from overweight Approximately every second of the clients at the clinic suffered from overweight. The reason for visiting the clinic was usually the need for guidance in matters related to an illness such as high blood pressure, diabetes or diseases of the musculoskeletal system. Slimming was generally included in the counselling but no health education programme was available for that purpose. Forms for documentation were unsatisfactory and documentation inaccurate which also prevented systematic counselling.

Group counselling of clients suffering from high blood pressure In group counselling the identified problems were: forming the groups; mobilizing resources and compiling the needed information.

Offering nursing in the home to clients suffering from multiple sclerosis Home care of MS patients required special arrangements and personnel. The situation was psychologically and physically exhausting both to the patients and to the nurses. The same problems were the concern of other health professionals and the family members as well. Nursing initiative was non-existent and care provided to the patients was mainly medically prescribed. There was lack of collaboration between those who cared for the patients. There was shortage of personnel. This long-term illness caused dependence on other people in activities of daily living and that resulted in anxiety in all involved. The facts that the relatives became tired, the patient had fear of being rejected and that care of a MS patient was labour intensive, prompted the project.

Promoting self-care of patients suffering from diabetes In the health policy perspective, diabetes was considered to be a significant problem. Problems and shortcomings identified by the participants were: repeated readmittances; lack of information about problems in patient care; no overall care plan and, due to short hospital stay, the care programme was left off; contacts with the non-institutional care were lacking and some patients were without a permanent contactpoint; monitoring and evaluation of care were unsatisfactory; there were problems in interaction with the patients and the patients did not absorb the counselling given to them; there were concerns with regard to the support required by difficult patients and matters related to physical needs of patients were documented but there were few comments about the preconditions of self-care.

Counselling diabetic patients for discharge from the hospital Diabetic patients did not receive systematic, need-based counselling. There was no framework for counselling and its content, material, and methods were unclear. There was no explicit division of labour between the health professionals who gave guidance to diabetic patients. There was lack of time for counselling due to the fact that a counselling nurse was not available. Collaboration with the personnel in non-institutional care was undefined.

Teaching self-care to patients suffering from asthma Knowledge about asthma as an illness and about its symptom control were insufficient among the patients, their relatives and the personnel. This had resulted in impairment of the health status and quality of life of asthmatic persons. Examples of that impairment were repeated admissions to the hospital. Asthmatic patients were lacking self-care skills. There were the following defects in the counselling system: needs for patient teaching and teaching objectives were not defined; lack of planning and incoherence in implementation, evaluation and documentation of patient teaching. Division of labour in patient teaching was unclear and personnel experienced that its knowledge and skills were inadequate.

The rehabilitative approach in psychiatric nursing Recipients of nursing care were passive, dependent and retained the role of a patient which prevented rehabilitation. Patients' families were not involved in the rehabilitative care. Nursing was task-oriented and the patient was an object of action. Mainly symptoms of patients were documented. Little personal interaction existed between the patients and nurses. The team providing care knew what was best for the patient. There was a great resemblance between the rehabilitative plans for different patients. Time was tightly pre-scheduled and it was the task of a nursing team to control that the schedule was followed. If the patient was unable to follow the schedule the reasons were not explored but it was concluded that the patient did not belong in the rehabilitative ward. The healthy aspects of the patient were overemphasized and his or her illness was not confronted, and consequently, the rehabilitative efforts did not succeed.

Intensifying the admittance phase in patient care on a psychiatric ward The admittance phase was routinized. It took time, before the focused interaction with a new patient was initiated and only some patients had a primary nurse. Especially in the cases where the patient was depressive or reacted negatively to his or her own care, it was difficult for the personnel to initiate primary nursing relationship. Patients' problems were identified but individualized care plans were not prepared for all patients. Patients had little opportunities to participate in planning their own care. Many caregivers were passive in regard to care planning. Nursing personnel did not adequately deal with the patients matters related to living in such a community as a psychiatric ward. Continuity of care was considered important but before the development project, planning for continuity was delayed. Patients were given little responsibility during the hospital stay and the role of the family in the care of a particular patient was unclear. The prevalent division of labour within the nursing team did not support sharing of clinical information, which was criticized.

Project covering nursing in the following environments: medical, surgical, ear-nose-throat, and ophthalmological wards The principle of individuality was not realized, nursing was task-oriented and there were difficulties in coordination. In in-service education disease specific lectures by physicians were a typical content. Nurse managers concentrated on recruiting manpower at the expense of the content of nursing. There were performance demands but scarce resources and as a consequence the vision in nursing was narrowed down and work motivation decreased.

Nursing care of stroke patients at all hours of the day The group of apoplexy patients was large and its care had economic implications. Not only economic interest but also human interest was behind the selection of this group of patients to become the focus of the project. The standard of nursing alternated according to the time of the day and according to the performer of nursing care. No criteria existed for monitoring the care of these patients. The efforts to intensify the care were thought to result in a decrease in the level of disability.

The physical environment and its impact on meeting essential nursing needs of patients in a psychiatric hospital Research questions were: 1) how is a psychiatric inpatient experiencing his or her physical institutional environment? and 2) how is the physical institutional environment supporting planned nursing care?

Medical nursing with special emphasis on care of patients suffering from renal disorders 1) Nursing was technically safe, specialist care. Nursing was task-oriented, routinized and built on hierarchical thinking. Nursing concentrated on physical and medical problems and was poorly documented, whereas medical orders were recorded systematically. Different groups of care providers worked individually without mutual coordination. Specifically patients suffering from renal disorders required long-term

care, hospital periods were recurrent, and the illness as such was chronic and disabling.

2) Personnel had observed that patients suffering from renal disorders did not feel well and their conditions deteriorated more rapidly than expected. Personnel experienced that their knowledge and skills in solving problems emerging in the care of those patients were inadequate.

Nursing patients suffering from cardiac infarction 1) The fear and depression of the patients was not sufficiently observed. Guidance of the patients was stereotyped. Nursing care did not adequately build on an individualized, need-based plan and the patient did not participate in dealing with matters concerning himself. Documentation of nursing was insufficient and inappropriate. Physical and medical matters were overemphasized in the documents. The phases of the nursing process were unclear and forms employed were outdated. Nursing personnel was not accustomed to document and did not necessarily appreciate it. Consequently, information in the patient records was interpreted differently by various care givers. Reporting in nursing was insufficient and its content was incoherent. The daily ward routine and the working schedule in the intensive care unit and on the wards hampered individualized nursing care.

2) The prevalence of cardiac infarction in the region and the strain its diagnosing and treatment put on the health care system. Biophysical care was prevailing and it was reflected also in the guidance given to the patients, especially counselling on matters like the mood of the patient, social situation and sexual life were inadequate. Patients experienced that mental support during hospitalization was not adequate. Patients' families were excluded from care and counselling. Continuity of nursing care was unorganized. Assessment of nursing needs, stating objectives, planning and evaluation were unsatisfactory. Professional nurses had too little time for direct patient care and their share in patient education was too small. There were among nurses lack of knowledge and discrepancies in knowledge concerning the care of this group of patients. Problems existed in the progressive system of care, especially in rehabilitation and after care of these patients.

Psychiatric nursing: nursing interventions in support of patients' participation in their own care By means of research to clarify the content of nursing and through that process to produce novel way of thinking, methods, and patterns of collaboration. To establish the custom to approach critically problems encountered in nursing.

Old age

Goal-directed/rehabilitative nursing of patients suffering from collar fracture 1) Procedures had a central role in care rendered and care offered was stereotyped, neither individualized nor comprehensive. Nursing as documented included recording of tasks performed, and patient's well-being and problems were excluded. Medical records concentrated on present diagnosis and only occasionally other diseases or problems of the patients appeared in the documents, which indicated withdrawal from the patients.

2) The questions asked were the following: What were the prerequisites for nursing personnel to employ the nursing process in practice? What is the domain of nursing? What patient problems, nursing objectives, plans including nursing interventions, implementation of plans, and evaluation were identified and/or documented?

Geriatric nursing: goals, principles and strategies The dependence of the clientele had increased; bed occupancy was high; the ward had 24-hour emergency service; there was lack of centralized services; there was shortage of staff; the amount of substitute personnel was great and developments in medicine and technology [had an impact on nursing requiring changes].

Developing counselling for the elderly Health education clinics serving specifically the elderly, were a fairly new development; their functions were not known and clear to people. Clients were expecting sickness care and some of them were disappointed with the encouragement to self-care and independence. Some uncertainty existed in the non-institutional care sector as well. Personnel in those clinics aimed at providing support for independence instead of performing procedures and giving directions. Nursing assessment and plan were not documented satisfactorily. In documentation, the physical health of clients was more emphasized than mental and social health. Documents did not secure continuity of care.

Promoting and maintaining health of people living in a residence for the elderly The elderly residents had not learned to take care of their own health and were in poor health. Eating was irregular, personal cleanliness was occasional and outdoor activities were almost non-existent. The use of medication was irregular. Due to lack of money it happened that the elderly was not able to buy proper food. Loneliness was one of the biggest problems. There were few contacts with the residents and their family members and between the residents. The elderly seemed to need more and more help with their residence care. There were repeated visits to a doctor and repeated hospitalizations. The local hospital had suggested that the general health status of the elderly should be improved. Demented elderly under those conditions created special worries. Preventive nursing services were non-existent. Among those who contributed to the care of the residents, collaboration and reporting were insufficient.

Developing a patient/client classification system for home care Medical orders had a great impact on nursing which concentrated on physical needs and procedures but too often excluded human interaction and healthy functions of the patients. The different members of the nursing team did not have a common understanding of the nursing needs of their patients or of the content of nursing care required. There was mutual criticism within the team of the decisions made by other members of the team. There were complaints in regard to the excessive demands made by patients and even more often by their relatives. The situation resulted in uneasiness within the nursing team and it was reflected in patients as well. Purely counting the number of patients and home visits was seen to give an inaccurate picture of the actual workload.

A rehabilitative approach in long-term care in institutions and in community Long-term care was perceived as a significant segment in primary health care. Care of the elderly was anticipated to be a real challenge in the future and there was a need to find out how nursing could contribute to the outcomes of long-term care. The physical institutional facilities existed and there was time to focus on the content of services. There was the desire to integrate the rehabilitative ideology into the services. Especially in home care, planning required development.

Maintaining independence of the elderly patients The proportion of the elderly in the total population was increasing and the whole clientele was more aged. It became necessary to consider a more rational use of the resources. Collaboration required for the care of the elderly was insufficient and there were interruptions in communication between home care, outpatient clinic and the wards. In the environment which was previously oriented towards acute illnesses and the care of adults, the elderly as a long-term patient was considered to be troublesome. Care of the elderly was institutionalized, independence was not emphasized, and compartmentalization was

created due to the fact that every nurse cared for a particular patient according to his or her own philosophy.

Developing long-term nursing care 1) Patients were in poor health and maintaining their independence was not emphasized in a systematic manner. Rehabilitation was not given special importance. Patients' relatives did not participate in the care. There was a lack of equipment needed for patient care. The problem was expressed in the form of two questions. Why is a person admitted to the institution adapting to the setting within one day, in a manner that makes him/her unwilling to return home? Are we just performers of procedures?

2) The proportion of the elderly in the population was increasing. Task allocation was the prevailing pattern, and it was characteristic to nursing that procedures were performed according to the ward routine. Documentation was unsatisfactory. Patients were not regularly approached as individuals and consequently they became institutionalized in a short time. Time available to the personnel seemed not to allow adequate rehabilitative interaction with patients. On the other hand, patients themselves expected to become cared for. In some cases family members visited patients very seldom. Collaboration between various groups of personnel did not operate as expected in regard to rehabilitation and comprehensive care planning. Rehabilitation was not conceptualized as part of nursing.

Maintaining independence in long-term nursing care It was perceived that as a consequence of the development in non-institutional care, patients cared for in the institutions were sicker and in poorer health than before. It was recognized that there were signs of custodial care and routine and task-centeredness in the manner nursing was practised, and consequently nursing personnel did not experience its work as meaningful. There was no agreement among the patients, their relatives and the personnel on quality care. Collaboration with other health workers was occasional. The forms in use did not support a systematic approach and nursing care was poorly planned. In the documents, physical needs of patients were recorded whereas social and mental matters were not recorded to the same extent.

Developing home nursing for the demented elderly 1) Senile forgetfulness was recognized to be a symptom which was causing much worry to the family, neighbours, and caregivers of the patient and causing anxiety to the patient him-/herself. Care plans were lacking or they were unsatisfactory and mainly nursing procedures were documented. The elderly patients requiring care very often lived alone. It was assumed that the number of senile forgetful patients will increase and no agreed policy concerning the care of these patients existed. In the institutional environment the senile, forgetful elderly often deteriorates. It was considered important to explore whether non-institutional care is suitable for the senile, forgetful elderly.

2) In the future, patients cared for in their homes will be older than before and consequently, the number of senile, forgetful patients will increase. These patients had various problems in the home environment: difficulties in human relations, there was the danger of accidents, overuse and underuse of drugs, unbalanced diet, difficulties in handling personal matters and declining self-confidence. Patients often felt themselves insecure and abandoned. The prevalent pattern in domiciliary nursing was that the symptoms of these patients were attended to. Proper physical care was secured. Too many people took care of the matters of these patients and their care required a considerable amount of resources. The patients' prognosis was pessimistic and the members of the nursing team were often frustrated.

The reasons for initiating the projects in nursing education were:

Developing teaching in Nursing: correspondency between nursing, education and professional identity The overall development in health services system and particularly in the educational system led to focus the project on Nursing as a main subject in nursing education.

A demonstration project in nursing education: teaching the main subject Positively received impulse from outside.

The concerns and problems identified at the beginning of the Nursing Programme fell into three categories: (1) the life situations of clients were unacceptable or the conditions of patients were impaired due to lack of nursing care (for example, lack of quality of life of the elderly in a residential home or insufficient support of self-care of asthmatic patients); (2) there was dissatisfaction with the way nursing interventions were developed and performed (for example, in maternity care and school health services, new approaches were required due to the developments in society); and (3) weaknesses in the knowledge and skills of nursing personnel were identified (for example, weaknesses were recognized in knowledge and skills of nurses who rendered nursing care to patients suffering from cardiac infarction).

Several projects addressed topical issues and/or priority areas in the health field, such as cardiovascular diseases, diabetes, other chronic diseases, care of the elderly and long-term care generally; primary prevention and health promotion in maternity care and school health services and mental health issues. In many areas there was a lack of knowledge and skills among nurses. Necessary reporting and collaboration were not developed properly. Family or significant others were often excluded from the patient care. There seemed to be a kind of physical bias in the focus of nursing, but the importance of mental and social well-being were recognized. Providing health education, giving guidance and counselling were often identified as interventions requiring development. That is an area of significance in nursing, because it is an enabling one and leads to self-care and independence of clients and patients.

The problems summarized on the previous pages related to an area of the health services which did not officially exist to the health authorities. That was the service which according to the traditional expression covered 24 hours per day in the institutions and in the community served all age groups along the health care continuum. This was the service sector which was referred to by the Consultative

Committee by emphasizing that 'in the Nursing Programme, the obligation has been taken of the full utilization of the two thirds of the manpower resources in the health care system. Also after the Programme, the unconcerned utilization of that resource should be recognized and prevented'.¹ It is evident that a considerable amount of uncovered problems existed in nursing, which had a significant impact on the health and well-being of clients and on the recovery and well-being of patients. Furthermore, it can be assumed that the Participating Centres were not the only places where concerns in nursing existed, but that they exemplified a more common phenomenon.

Already at the beginning of the Nursing Programme it was documented that there had not previously been any mechanism which would have brought problems and concerns identified in nursing into discussion and under serious scrutiny. If the concerns of nurses which emerged from the problem statements summarized in this sub-section are looked at from the perspective of health policy, it can be asked why such shortcomings in health care had not been addressed earlier; they seemed to be quite significant and requiring attention. If the same problems are approached from the professional perspective, it seems to be justified to refer to a potential ethical dilemma. The situation described in this sub-section seems to suggest that the major moral dilemma of nurses is that there are organizational restrictions which have an impact on ethical practice (Davis & Aroskar, 1983; Yarling & McElmurry, 1986). Nurses revealed serious weaknesses in their own practice, thus exhibiting honesty which is essential in the process of clarification of values. At the same time, they demonstrated a positive view that it was possible to tackle the problems in a successful way. Preceding discussion on the ethical foundation of nursing has shown and the following discussion on nursing actions will show that nurses were able to demonstrate, that given the opportunity, the practice could be reoriented even without additional resources. The earlier reported discussion about the principles underlying nursing can be seen to represent a kind of ethical reorientation which was created as a reaction to the observations made by nurses themselves.

¹Minutes of Meeting 9 March 1982

4.4.3.2.5.2. Nursing as developed in response to concerns expressed

The content and scope of nursing practice in Participating Centres is presented under four categories. These categories are identifiable and interrelated units in nursing and its organization, and in principle, the preceding unit is included in the next (i.e. number 1 beneath in 2, and both 1 and 2 in 3). Nursing can be developed and investigated by focusing on one or several of them. The manner in which nursing was described in the final reports presented a comprehensive and interactive outline of the units, and therefore, the following categories, separated as they are, serve only as units of the analysis:

1. nursing interventions or means by which nurses accomplished their function;
2. the nursing process as a method and a key content of the Nursing Programme;
3. a clinical model which included a varied range of direct nursing measures along with the principles; and
4. a management model or nursing strategy in which some additional, mostly structural, elements were included in the total picture of nursing.

Some clarification may be required in regard to the other metaparadigm concepts which have been discussed in previous sub-sections. The final reports seem to suggest that the concept of 'man' and the principles drawn from it had a real impact on nursing action; in other words, as can be expected, the ethical foundation guided the practice of nursing and the practice was repeatedly discussed in the light of the principles. It appeared that the ethical foundation had a stronger impact on actual practice than the theoretical foundation. Yet, a firm orientation or intellectual stimulus originated from nursing theories as well. Probably the best examples of the cognitive dimension of practice are the concepts of 'self-care' (Orem, 1985) and 'nursing needs' (Yura & Walsh, 1978). It is contended, however, that the general feeling among nurses, of possessing more clarity in regard to nursing, can be attributed to the attempts to explore contemporary nursing theories. Principles of nursing were often presented as an integral part of the overall development. The understanding of 'health' formed a background of many solutions made in nursing; for instance, in regard to assessment tools or nursing interventions. The 'environment' was often attended to for the improvement of the quality of nursing care. All the quotations used in this sub-section

originate from the unedited final reports of health centres, hospitals and schools for health personnel.

Nursing interventions

Material presented here, was recorded as descriptors when changes taken place in nursing were discussed or a novel practice model was dealt with. They are identified as nursing interventions by the investigator and classified on the bases of their focus and purpose. The following types of interventions can be identified:

Human interaction and equal patient/client - nurse encounter Examples of this type of interventions include: giving time, giving one's self to the interaction, being present, listening, observing (with sensitivity; recognizing the needs of individuals and families, identifying pupils at risk), interviewing, asking questions, discussing (focused, confidential discussion), reading to the patient, respecting individual wishes, accepting individual reactions, human touch and caring. A special case in this category was the nurse - patient interaction in mental health nursing.

Encouragement and support These were accomplished by placing oneself beside the client, by providing security, by showing warmth and understanding, by strengthening self-reliance and self-esteem, by consolidating family cohesion, by calling forth belief in one's own possibilities, by supporting independent coping, by offering an object to identify with, by fostering collaboration, by communicating that it is acceptable to be autonomous, by giving stimulus for independent endeavours [in health care], by helping, by supporting self-care, by giving information to provide a basis for the patient's own decision-making, by strengthening the problem-solving faculty [of a patient/client], by help and support of acceptance of the situation, as the case may be, and also impending death.

Health education and patient teaching This type of intervention was developed through careful assessment of learning needs, through developing teaching programmes and guidelines related to those programmes, through producing teaching/learning material and through evaluating learning outcomes. A special item under education/teaching was extending guidance to families and relatives. Guidance and support as an intervention appeared together in school health. Health education and patient teaching took place on the level of an individual or it was implemented in various types of groups. Health education and patient teaching were the most prevalent interventions indicating that an attempt was made to support autonomy, independence, and self-care.

Psycho - physical nursing interventions Recorded in the final reports were the following interventions: washing and dressing a patient or helping a patient to do it himself, preparation for an operation, monitoring patient's condition, pain management, necessary procedures for ensuring elimination, consideration for a need of special aids and teaching their use to a patient, providing meaningful activity and rehabilitation.

Social - environmental nursing interventions Characteristic to this group of interventions was that they were mainly - but not exclusively - related to the indirect care of patients/clients, such as providing continuity of care, organizing the

environment (to provide privacy or to prevent depression), providing orientation by lighting conditions, providing an aesthetic environment, rich and varied collaboration with a patient/client, family members, other health care providers, other sectors or departments of a given institution, between institutional and non-institutional care settings; in long-term care settings organizing festival or celebration. Maintaining social contacts of a patient was used as an intervention as well.

As was noted before, this type of content of nursing practice was not developed as focused interventions but rather became a part of the general picture through the interplay of the theoretical and ethical foundations of nursing, contemporary goals and understanding in the profession of nursing and of practicalities in the health care system. The interventions demonstrate the complexity of the practice of nursing and the variety of approaches in its use. They indicate as well that neither types of interventions, nor the individual interventions are mutually exclusive and the purpose of an intervention and the intervention per se may be interwoven. For example, listening is a part of patient teaching though it may be considered an independent intervention as well; or working in small groups with clients may foster maintenance of social contacts. This complexity and interconnectedness is characteristic of nursing.

The nursing process

All the Participating Centres employed the nursing process in the care of those patient or client groups which were included in the Nursing Programme. The comprehensiveness of this method varied from centre to centre and it was indicated in the reports that its implementation on the whole was not an easy task. Also several weaknesses (e.g. in stating objectives or in evaluating systematically) were reported. Certain general features can be drawn from the written material. Quite extensive assessment tools (or nursing history or interview schedule) were developed and tested by nurses. These tools - together with the guidelines for the users - demonstrated the emphasis on an individualized and holistic approach as well as patient/client participation. In some instances, these clinical data collection instruments were constructed by interviewing intensively a small group of recipients of nursing and so obtaining a thorough picture of the situation of a particular client group. The nursing care plan was the other data recording form developed, obviously with less difficulty. However, documentation as such was a constant concern of the nurse participants. According to the nurse authors, the ethical foundation was reflected in the nursing

process and specific nursing interventions became its parts. The following quotations describe the development:

However, a patient is not yet treated as a fully autonomous thinking individual... (Report from a health centre, no. 1, p 50)

Every pupil got an opportunity to be treated as a unique individual. The bio-psycho-social whole of a person was easy to perceive and analyse with the pupil himself/herself [due to the assessment tool]. (Report from a health centre, no. 4, p 28)

A need for mental support of patients has received more emphasis when nurses know their patients better. This area has caused most anxiety and feelings of inadequacy among nursing personnel. (Report from a university central hospital, no. 29, p 46)

A clinical model

Under this sub-heading, those novel practice models of nursing are presented which seemed to be broader than the nursing process (which was used as an umbrella in conceptualizing clinical practice) and which formed a coherent whole. An illustrative example might be a model developed for the home care of the elderly with senile forgetfulness. That model 'is based on those human needs which forcefully emerged when an in-depth exploration of the whole life situation of the elderly was made' (Report from a health centre, no. 11, p 12). In addition to the most prevalent needs, the model includes frequently identified problems, realistic objectives and interventions for nursing care, suggestions for evaluation, as well as some specific suggestions which would facilitate the interaction between the elderly and a nurse.

It was characteristic that in a given model, a need-based and interactive approach was emphasized along with highly individualized means. A true participation of the recipient was a typical feature. A model might focus on maintaining and promoting activities of daily living, on basic nursing in a long-term care setting, on assessment of self-care capacity and consequent support to self-esteem and independence, or on an intensified and individualized teaching programme incorporated with the principles of nursing and the nursing process. Moving from a naturalistic concept of 'man' towards a humanistic one and broadening the concept of 'health' might be the ingredients of a

model. The importance of documentation was noted separately though documentation can be seen as part of the nursing process. Development and use of dependency scales and constructing standard care plans were mentioned. A quality assurance programme along with the individualized and systematic nursing was one instance of clinical models.

A management model

This was a model which included all the previous actions but incorporated a wide range of supportive activities such as: research as part of nursing and its development, in-service education and supervision. Patterns of nursing, i.e. task allocation, group work and primary nursing in focused and intentional use and developing the content of reporting to serve individualized and holistic nursing, had an important role; adjusting daily timetables and ward routines according to the needs of patients were supposed to add to the quality. Constructing the environment with nursing principles as a vantage point and purchasing of goods according to the needs of patients were ingredients of some models. The most salient feature of the overall model was the collaborative working relationship with parties involved in the health care.

In summary, the final reports reflected both the content and scope of nursing action. The nature of nursing, as it was practiced in various settings, was described in a narrative form so that it integrated originally separate ingredients such as a conceptual framework, principles and organizational arrangements. In analysis, nursing action was described by employing four levels of descriptors which differed in scope but at the same time were overlapping and integrated. Those four levels were nursing interventions, the nursing process, and clinical and overall management models. Several categories of nursing interventions were identified. Those included interventions related to human interaction and to the attempts to provide encouragement to patients and clients in their highly individual situations. Educating and teaching nursing clients for health and self-care was a much used intervention. An earlier prevailing category of interventions, that of psycho - physical approach, was often present in the novel practice models for nursing but were not extensively commented on. Social - environmental interventions were an essential element in the management model.

The nursing process as a method and also as an organizing conceptual tool was developed. There was a clear indication that through the assessment phase an individualized and holistic approach was developed and through the planning phase a more systematic working pattern was established. Nursing interventions were included in the implementation phase. The clinical model had the nursing process as its ingredient but it also incorporated other elements, such as enabling the full participation of the patient/client, implementing primary nursing as a philosophy and combining activities which could promote independence and self-care. Identified principles of nursing were the essential elements of the model. The management model included structural elements to support the clinical model, such as environmental factors and resource development. In summary, the four interrelated elements of nursing action are presented in the following figure.

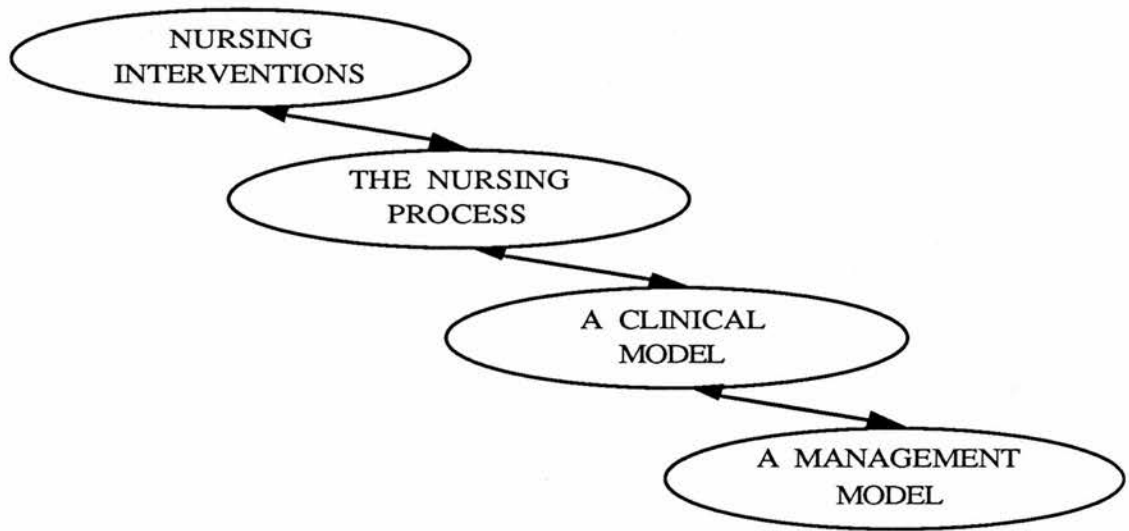


Figure 4.4. The content and scope of nursing action

The comments made by the nurse participants about their experience in the Nursing Programme conveyed two basic messages: participation in the Programme was demanding, heavy and sometimes arousing an experience of negative feelings, but at the same time it was a great and rewarding adventure. Community nurses wrote about their experiences at the outset of the Nursing Programme:

I had no idea about how much time and mental resources this project would require from me. Had I known it, I probably would have refused. (Report from a health centre, no. 13, appendix 8, p 1)

[The first year] was a time for developing one's own personality, for learning systematic thinking, for digesting new knowledge and for developing nursing philosophy of one's own. (Report from a health centre, no. 11, p 9)

The accounts of the Contact Persons dealt with earlier in this chapter, did not stress the shortage of nursing manpower. The final reports indicated that there was a shortage of nursing personnel and a lack of time, with very often a conflict between being with patients/clients or learning new things and doing paper work. The following quotation from a central hospital is indicative in terms of resource management:

Nursing personnel has been willing to develop its own work, to improve its creativity and effectiveness, otherwise, with existing resources an increased and varied range of activities would not have been possible. (Report from a central hospital, no. 24, p 24)

The following quotations may explain why in the Nursing Programme positive feelings and forces were much stronger than the negative ones:

The best thing has been that participation in the development of nursing was not a privilege of the few; rather, in the whole clinic and at all hierarchical levels, an unforeseeably heavy, much energy requiring but rewarding process took place which laid the groundwork for continuous development. (Report from a university central hospital, no. 26, p 33)

Nurses have discovered new and surprising skills in themselves when they have given lectures and shared their knowledge with others. (Report from a university central hospital, no. 35, p 26)

Regardless of the difficulties due to the lack of time, members of the group have with enthusiasm and interest attended the development of nursing. Our experience is that it has given new content and new dimensions to nursing and its delivery in clients encounters. (Report from a health centre, no. 8, p 13)

Nurses felt that their own understanding of nursing had become clearer, regard for their own contribution to health services had been strengthened and willingness for continuous development had been established. The following quotation draws attention to a significant matter in the Nursing Programme:

It has been great to realize the existence of that huge potential resource [in nurses] which - if given the opportunity - could be employed. (Report from a health centre, no. 4, p 34)

Obviously, there was a considerable unused potential in nursing personnel. That potential made it possible for nurses to evaluate their own practice, to absorb new knowledge and to reorient their own practice. But that potential had to be revived and stimulated to make it active and functional. A mention was made in the final reports that the nurse participants had needed more support - especially at the beginning of the Nursing Programme - than the establishment was able to provide. In the Programme, this indispensable health resource was supported by extensive and continuous in-service education and supervision. It was considered a positive sign and outcome that to practice nursing required continuing supervision. Educational activities of the Centre of the Nursing Programme were part of this enabling educational effort. Judging from the final reports, it can be argued that nursing education as a topic of the Programme was justified. In other words, there were unmet learning needs and there was a gap in keeping up with knowledge development.

The schools of nursing participating in the Nursing Programme also indicated that there was room for growth and development. The following quotation from a school exemplifies that view and shows what kind of positive development was identified:

Collaboration between [nurse] teachers and between various parties involved in nursing education increased. The role of a teacher as an expert in nursing was emphasized...and through further education teachers had acquired new knowledge. The production of teaching/learning material by teachers increased. Attitudes towards teachers in practice settings were more positive than before and teachers were involved in the activities of those settings... Nurses who provided supervision to student nurses assumed a more goal-directed approach in their

guidance of students and showed interest in developing nursing education. It was assumed that nursing as practiced, served as a model for student nurses in a more positive way than before. Student nurses had become interested in self-directed learning and their skills in evaluating patient care and education improved. (Report from a nursing school, no. 41, pp 10-11)

To nurse educators, the points of emphasis and matters which became the content of teaching and learning were: abstract and critical thinking; autonomous knowledge acquisition and utilization; skills in interpersonal relationships (observation, listening, interviewing), psychomotor skills, teaching and supporting skills, collaboration, verbal and written expression and developing one's own personality. It was expected that education will support the development of professional identity. Nursing as a major subject in the curriculum, which provided a philosophical and theoretical framework for education, was a focus of the development.

Discussion In the discussion which follows, the nursing action data are dealt with in the process evaluation framework suggested by Donabedian (1966). Values and principles underlying nursing action were developed and made explicit. This process of values clarification combined the contemporary discussion on ethical principles with the thinking and experience of nurses. The principles appeared not only as theoretical statements but the reports systematically demonstrated that the implementation of those values and principles was established in the practice of nursing. The manner in which values and principles were presented suggested that they penetrated the whole management model. Such an ethical dimension in the practice of nursing is a positive asset.

'Capabilities of science and technology' is another facet in the evaluation of the process element. Donabedian's suggestion signifies that the adequacy of the knowledge base as a whole in terms of its power to guide services - e.g. as published research results - should be assessed. Though that kind of focus of an exploration would be significant and its results would benefit the knowledge development in nursing, that kind of exploration is outside the purpose of this study. However, a

reference can be made to some characteristics of the knowledge base and to the patterns of knowledge utilization.

As was discussed in the epistemological part of this study, the intellectual heritage of nursing is rich. Discourse within the domain of nursing as to what constitutes knowledge in nursing and how that knowledge may be acquired, is perceived as a natural development, which to a certain extent was reflected in the Nursing Programme. There were three contact points between the knowledge generation and utilization on one hand and the Nursing Programme on the other. Firstly, the Participating Centres involved themselves in the process of knowledge generation by investigating unexplored areas in their services and they used qualitative research methodologies in developing assessment approaches. Secondly, there were clear indications in the reports that the attempt had been made to use existing knowledge. However, it was the general conceptualization of nursing, i.e. nursing theories, which provided the stimulus to practice and education. It is argued that the reasons for this emphasis were similar to those which once prompted the theory development: there was an urgent need to see the comprehensive conceptualization of nursing and there was a need to understand one's own position against that conceptual background - and possibly to contribute to that development. There was less evidence of the systematic use of research findings. Thirdly, the reports reflected the intuitive knowing in nursing. This pattern of knowing seemed to have emerged spontaneously rather than as a result of a special effort to seek that type of knowledge.

At the outset of the Nursing Programme, a lack of knowledge and skills in certain areas of nursing was realized. The entire national and local educational programme and information delivery aimed at application of available knowledge. Wide implementation of the nursing process was not only a practical activity, it was also a cognitive activity. On the whole, development in the Participating Centres suggests that a significant move towards knowledge utilization took place. The experience, the shared level of understanding and the decision-making of nurses themselves guided the development.

Through the involvement of the recipients of nursing - though it was not yet complete - the views of this group were sought through investigation, in depth interviewing and involvement in the nursing process. The opinions of patients and clients were taken into consideration in a more systematic manner than before. The concepts of health and illness as outlined by nurses and as put into practice, suggested the presence of health promotion and illness prevention. Furthermore, it seemed to be characteristic of nursing to perceive health as a bio-psycho-social entity as well as conceptualize it mainly as coping, or everyday management of life. Nurses did not write about coordination the way they wrote about collaboration with those involved in patient care. That was a pervasive feature of the novel practice models of nursing. It can be concluded that nurses initiated that collaboration. In many instances, collaboration was necessary to secure continuity of care.

It is significant to note that what has been presented as nursing action by nurse authors, most probably reflected both the ideal model of nursing and the actual practice of nursing. Though it may be true that every recipient of nursing was not treated according to the best ideals, the existence of novel practice models and knowledge about their feasibility (obtained through practice more often than through research) is considered a significant achievement.

Some patient outcomes were reported with great caution by nurse authors. The following were the examples. In psychiatric nursing, the rehabilitation phase began earlier than before and thus at a more severe stage of illness and patients did not discontinue their care as before. Among newly diagnosed young diabetics, motivation for care remained high and the balance of their diabetes was particularly good. In the long-term care institutions the observation was made that regardless of the fact that their patients were older and required much care, there was less dependency and turn over of clientele was accelerated. Those types of observations were significant because they were made on priority areas of health policy and pointed in the right direction. In the next section, patient/client outcomes are further discussed on the bases of their own views.

4.4.4. The outcomes as perceived by patients and clients

Views of the patients and clients are presented on the basis of a survey (N=301) introduced as a part of the method. From the original study population of 315, altogether 14 subjects were excluded. Eight (8) subjects were excluded because a member of health centre or hospital staff had assisted with completing the questionnaire. From the original study population, six (6) subjects were excluded due to the fact that only demographic data were available in the questionnaire. If there was information of categories of interest though there were missing values - this was often the case with the elderly respondents - the subjects were included in the study. This resulted in a situation where the tables created with MINITAB were not based on the same number of observations. Therefore, for comparison, percent distributions were utilized. Instead of the formal Chi-square test (Mills, 1955), the following formula was used in the analysis to identify differences: observed value minus expected value was divided by the square root of the expected value. This approach was selected because there was an interest in qualitative results in the study.

Of the 301 study subjects 34% were males and 66% were females. The age distribution in the study population was the following: 0-5 year olds 10%, 6-14 year olds 3%, 15-19 year olds 3%, 20-34 year olds 23%, 35-64 year olds 30%, 65-74 year olds 17% and 75 years and over 14%. Of the study population, 8% were patients in psychiatric hospitals, 15% were patients in university hospitals and 16% in central hospitals, the rest 61% were clients of health centres. The reason for contact with the health service system differed. Health promotion, health maintenance or preventive measures were the reasons for contact in one fourth of the cases. For 14% of the subjects, the reason for contact was pregnancy or delivery. Half of the respondents indicated the reason to be physical illness and 8% said the reason was mental illness. In few cases (less than 2%) the reason for contact was social or it was related to rehabilitation. Frequent contacts with the health service system had had 43% of the patients and clients and the same per cent had had infrequent contacts, whereas to 14% of the respondents the contact (related to the study) was the first one. Of the hospital patients and clients in domiciliary nursing care (N=187), half had stayed in care less than two weeks, and the rest of the subjects had stayed more than two weeks. One fifth of the patients and clients had stayed in care six months or more.

Responses of patients and clients are scrutinized in the light of the principles documented by the participants of the Nursing Programme. A description is made of the extent to which the implementation of the principles and knowledge was reflected in the experiences of the patients and clients. Particularly the holistic approach to a person, support of patient/client independence and their participation in their own care are observed. In terms of Donabedian's (1966) outcome approach, this discussion will address some aspects of health related knowledge, end results in patients/clients, and some aspects of patient/client satisfaction.

The experienced independence and/or dependence - as a reflection of the behaviour of the personnel - among the recipients of nursing care is discussed in relation to age, study setting (i.e. Participating Centres) and reason for contact. There were some differences between the age-groups in this matter. There was the greatest experience of independence among the 0-5 year olds (i.e. among their parents) (44%), 15-19 year olds (42%) and 20-34 year olds (38%) compared to an overall average of 30%. The greatest dependence also occurred in the 15-19 year old group (32%). This age group was different to the others in that the group very seldom experienced independence and dependence to be equally important.

Most independence occurred in health centres (34%) and psychiatric hospitals (37%) and the greatest dependence occurred in university hospitals (31%). The greatest independence appeared among those whose reason for contact was pregnancy or delivery (41%). The greatest dependence was found among those whose reason for contact was mental illness (23%) or physical illness (26%). The result that most independence occurred in psychiatric hospitals and considerable dependence was found among those whose reason for contact was mental illness, seems contradictory. This anomaly was basically due to the fact that comparison was made between groups differing in size. It appeared that the kind of assessment which can be considered thorough according to the standards of nursing, was linked with greater independence and less dependence. Patients and clients also experienced greater independence when given the opportunity to participate in planning, and vice versa. On the whole, however, the prevalent pattern was that creating independence and dependence were considered to be equally important as a behaviour pattern of the care providers (except

in the group of the 15-19 year olds). The results indicated that remaining independent or becoming dependent was a situation-specific matter and the positive goal of independence seemed to be related to the pattern of assessment and planning promoted by the Nursing Programme.

Assessment The pattern of assessment phase seemed to be similar in all age-groups and in all settings. The major differences were, that school children gave 'can't say' answers and patients in psychiatric hospitals gave a lot of 'no' or 'can't say' answers - when the content or style of the assessment were dealt with. On the whole, the nurse-patient/client interaction at the assessment phase seemed to be characterized by the following features: patients and clients had the opportunity to express their feelings and views, matters of importance to them were dealt with and the nurse in discussions had concentrated on showing interest and empathy. However, in more than a half of the cases, the recipient's opinion of his own health status did not constitute the starting point of his care. Keeping in mind that a clear majority of patients and clients had the opportunity to bring to the attention of their nurses matters of importance to them, it is indicative, what the respondents reported about the scope of the discussions during their stay in the hospital or when visiting the health centre. The data suggested that the scope of attention had broadened when compared with the problem statements as they appeared in the final reports and were summarized earlier in this chapter. Matters related to a person as a psycho-social being were a part of communication content. However, physical matters formed the dominant category in communication content.

Planning Slightly more than a half of the recipients were encouraged to become responsible and make decisions as a part of the planning process, and the opinion of care was sought from the similar percentage of them. The 6-14 year olds, patients whose reason for contact was mental illness or who were in psychiatric hospitals, had difficulty in saying whether they were able to participate in planning. Three quarters of all patients and clients considered that they had received enough information to form the basis for decisions; the opinions of a patient/client had been respected in two thirds of the cases. From the patient/client perspective, nurses seemed to aim at prevention, comforting and good physical care. The following groups could not identify the objectives of the nurse or felt that the objectives listed did not concern them: the 6-14 and 20-34 year olds, and those whose reason for contact was mental illness (those in

mental hospitals). In addition, certain objectives seemed very badly covered in particular groups. For example, those whose reason for contact was pregnancy or delivery did not think that prevention of illness had been the objective of the nurse. Comforting did not appear as an objective among those whose reason for contact was social or who belonged to the age-groups of the 0-5 or 65-74 year olds. On the whole, however, it seemed that patients' and nurses' objectives were in agreement: 95% of patients/clients who had cognitive objectives said the nurse also had cognitive objectives, 81% of patients/clients who had affective objectives said the nurse also had affective objectives and 83% of patients/clients who had social/interactive objectives said the nurse also had social/interactive objectives.

Patients and clients had a varied range of expectations. The main expectations concerning nursing care were physical/physiological functioning (28%), psychomotor skills (16%), cognitive outcomes (10%), affective outcomes (10%) and 'what received' (16%) (a category formed on the basis of the replies). The main objective was physical/physiological functioning for all settings except the psychiatric hospitals, where that objective was second after the objective of psychomotor skills. Younger age-groups had simpler spectrum of expectations than the others. Among the 6-14 year olds the main expectations were cognitive (50%) and affective (25%) by nature. Among the 15-19 year olds the main expectations were cognitive (50%) by nature and in compliance with 'what received' (33%). In contrast, older people (20 years +) placed more emphasis on physical/ physiological functioning and psychomotor skills as objectives. The main expectations varied with the reason for contact in ways that one would expect. For example, for physical illness the major expectation was physical (41%) and for health promotion the main expectation was cognitive (28%). However, the major objective for those whose reason for contact was mental illness was affective (40%) and only 5% said the objective was psychomotor skill.

Implementation Which kind of nursing interventions are appropriate first of all depends on the needs of a patient/client. It can be assumed, that on those grounds, the respondents have answered the question of the content of nursing care. Nursing interventions covered physical, mental, and social areas. On the whole, for those who needed it, physical care was most satisfactory, psychic care was not quite so good and social care was worst. Patients/clients indicated that appropriate care of the individual

was the major intervention for different age-groups, settings and reasons for contact although there was some variation between the spectrum of interventions. For example, life-style conducive to mental health was also an important category of interventions. There were fewer interventions in the social category but there were fewer expressed needs in that area as well. Nursing interventions were most frequently focused on nutrition, sleep and rest, health education, pain management, body movement, elimination and relief of anxiety.

Evaluation Recipients of nursing care estimated that about 80% of them had received enough knowledge to enable them to take care of themselves. The rest of them did not have that experience. On the whole, one quarter of the recipients had learnt something about life-style conducive to health or its preconditions and one quarter had learnt about appropriate care for an individual. If the information received for the continuity of care was not satisfactory, patients/clients were generally less satisfied with their care. Patients and clients were equally informed in all age-groups, settings and reasons for contact. The major differences appeared among the 6-14 year olds and those whose reason for contact was mental illness/those in psychiatric hospitals. These groups tended to indicate their uncertainty in regard to this matter. The main thing learnt was appropriate care for the individual, except in psychiatric hospitals where the main thing learnt was life-style conducive to health. This was the second major thing learnt in the other settings. The main difference between primary health care centres and hospitals was in prevention and appropriate care. There was more emphasis on life-style and appropriate care in the university and central hospitals. In fact, all the categories involving some prevention tended to be given more emphasis in the primary health care centres.

Some patients/clients felt that the outcome of care had exceeded their expectations, two thirds of them reported that their expectations were totally met, and the rest of them felt, that to a varying degree, their expectations were not met. For the expectations having affective, cognitive and social components, patients/clients showed less satisfaction than for the cognitive/physical and 'what received' expectations. However, the spread of satisfaction was wider for expectations containing affective and physical elements, i.e. nursing care received exceeded the expectations or the expectations were not met at all. Those patients/clients who had received thorough

assessment and who had the opportunity to participate in planning were more satisfied with their care than the others. There were some differences in the pattern of expectations materialized across the age-groups, settings and reason for contact. In general, the middle-age-groups seemed less satisfied and the young people tended to be uncertain in regard to satisfaction more often. There was also less satisfaction with care in psychiatric hospitals and among those whose reason for contact was mental illness. Most satisfaction was attained in central hospitals and equivalent.

Discussion Taking into consideration the rather narrow scope of practice at the beginning of the Nursing Programme - described in the final reports - the data on assessment and implementation suggested that an unbalanced approach had given way to a more holistic approach in nursing. On the whole, patients'/clients' and nurses' objectives were in agreement. There were more signs of satisfaction than dissatisfaction and satisfaction seemed to relate to a thorough assessment and the opportunity for participation. However, there was a minority of patients and clients whose responses indicated lack of the kind of nursing which would have met their individual needs. Particularly young age groups and those with mental illness showed special features requiring further exploration. That can be considered as lack of equity and therefore a challenge for nursing. The results also indicate a need for such research approaches which include the process of nursing in totality; in other words, there should be the possibility to explore the relationship between assessment data, identified needs for nursing, stated objectives, nursing interventions and outcomes, both from the perspective of a patient/client and a nurse.

4.5. Epilogue

It has been made clear before, that one of the major ideas of the Nursing Programme implementation was that research and development activities from the initiation of the project would become integrated into everyday practice and management. There was, however, a last joint intervention of the Consultative Committee and the Project Group which was meant to secure a positive further development. Through letters to the Minister of Social Affairs and Health and the Director General of the National Board

of Health, recommendations based on the Programme were made known to the health authorities.

By interviewing (1989) with two government officials the previously mentioned letters were followed in the archives of the Ministry and the Board. Those interviewed explained the handling of the recommendations. The archives told their own story. In the Ministry of Social Affairs and Health it was discovered that the reception of the letter was recorded, according to rules, but what decisions had been made or what actions were taken was not recorded. This is quite exceptional in a government office where the matters are normally documented as a decision made or as a selected measure. At the National Board of Health, the meeting of the Collegium never dealt with the letter. However, the further measures included in the letter were twice on the agenda of the special meeting of the Collegium. No minutes were available of those meetings. A suggestion concerning the establishment of an expert committee on nursing has been a topic of internal discussions at the National Board of Health after the Nursing Programme.

If a comparison is made with a family doctor project in Finland which was implemented simultaneously with the Nursing Programme and into which the Nursing Programme was integrated, two different types of developments can be seen. The initiative for the family doctor project came from the National Board of Health and the project became a regional effort. The Nursing Programme was initiated by the WHO/EURO together with the profession of nursing and it became both a national and an international project. The family doctor project got a successor supported by the health authorities when the project for developing and experimenting with the primary physician system was instituted. At the same time the Nursing Programme was administratively forgotten.

The health authorities which gave the Nursing Programme its official status and also financed it, could not point out concretely that anything would have been built on work done in the Participating Centres. The achievements of the participants however supported in many ways the official health policy by enhancing health services, by developing the appropriateness of the content of services, by focusing on major

widespread diseases and long-term care, by developing health education and patient teaching and by developing cooperation between health care institutions. Furthermore, soon after the completion of the Nursing Programme, the Ministry of Social Affairs and Health launched the national 'Health for All' programme (Sosiaali- ja terveystieteiden ministeriö, 1986) as an invitation to intensified action. The health authorities however, did not give any significant recognition to what had already been accomplished in nursing. With the basis of broadened knowledge and understanding and its practical demonstrations, nursing could have become a major force for change.

This situation parallels with that discussed by Garling in 1985 as she commented on implications of the 1910 Flexner Report and the 1923 Goldmark Report. Both reports dealt with educational matters. The impact of the Goldmark report has been a minor one when compared with the Flexner report though there was no difference in the status of the reports.

5. Conclusions

Conclusions are framed on the basis of the analysis covering the years 1979-1983. In addition to the conclusions drawn, relevant content in the form of postscripts is included to provide an update about the same areas of discussion, and to provide a greater opportunity for observing the direction of change in nursing.

Organizational characteristics of the Nursing Programme The higher the level of an organizational element in the overall hierarchy, the more mechanistic and political it was, whereas the lower the level of an organizational element, the more it exhibited organic and brain-like qualities. It was evident that nurses were not prepared for meeting the reality which, among other things, made nursing in important respects dependent on an organization which was complex, ambiguous and paradoxical (Morgan, 1986). There were very few signs in the documents which would have indicated that nurses, the promoters of the Nursing Programme, had recognized the unfavourable decisions or movements in their immediate surrounding.

The mechanistic organizational design of the Nursing Programme could have been the most significant single characteristic through which the organization can be read and understood. The mechanistic model brought to the top of the organizational hierarchy a very varied collection of interests. Most probably, the relationship of this organizational element to the content of the Programme remained mechanistic as well. The most powerful element of the organization (i.e. its steering system) recorded few truly supportive measures, it ignored several topics of crucial importance to the Programme and nursing generally, and it mobilized very minor resources for the actual work in the Programme. Its mere existence constituted its major support.

Perhaps a decisive characteristic of the top of the organizational hierarchy was that it seemed to be divorced from the essence of the Programme which was the promotion of nursing services in a manner, which would lead to a continuous dynamic

development. Its authority was available for administrative operations, i.e. for meetings, and monitoring that plans were produced and reports submitted. The Programme technically was the focus of the action but not the purpose for its existence. The top of the hierarchy did not involve itself in real issues in nursing, for instance in those reported as problems in the Participating Centres. It may be argued that the organization was incompatible with the mission it set out to accomplish. Two ministries, three national boards, professional associations, and other important organizations related to nursing were involved in and brought their advice to the Programme by occupying decision-making posts. Disagreement between the government authorities and the nursing profession about the nature of nursing and about nursing education, or the uncertainty the dynamic development in nursing caused to the medical profession, were reflected in the organizational behaviour of the members of the steering system. It is assumed that what took place at the top of the organizational hierarchy reflected more general attitudes towards nursing and attitudes operating in other situations as well. The steering system provided a good opportunity for effective control of the advancements in nursing.

The organizational model placed at the bottom of the hierarchy the most valuable resource in terms of the objectives of the Nursing Programme. The instrumental part of the organization in terms of the goal-attainment, was the brain-like functioning group of organizational participants in the Participating Centres. Obviously, the period of autonomy which the Programme created, provided a positive opportunity for nurses. The Programme was implemented - more or less - based on professional interests and promoted by gradual achievements, but it was not based on authoritative demands. Those professional interests were not in discrepancy with the official health policy, and that justified their existence. Politicking and lack of consistency in the steering system could not prevent the productivity of the periferal small units of nurses which operated like brains, and thus demonstrated the feasibility of a holographic organization. Through these small units actual nursing practice was reoriented in a manner which exhibited general trends both in the health policy (cf. Table 1.2.; World Health Organization, 1986) and in the profession of nursing (George, 1985). This level of the organization can also be seen as a demonstration of the readiness for professional autonomy.

Within the organization, clinical groups demonstrated their ability. They exhibited a considerable information-processing capacity in their efforts to integrate nursing knowledge into the Programme and make it innovative and coherent. The information processed and applied was part of the common knowledge base in nursing which was introduced as the epistemology of nursing. It is argued that there were great similarities between epistemology of practice discussed by Schön (1983) and the way nursing was conceptualized and analysed in practice by nurses, thus demonstrating intuitive knowing in nursing (Agan, 1987; Carper, 1978).

In a large scale, the Nursing Programme mirrored the more general development in the nursing profession. In its attempt to bring its initiatives to completion, the nursing profession was to a surprisingly great extent dependent on outside forces and authorities; in other words, the scope of its authority was very limited. The Nursing Programme was a kind of microcosm of nursing; the Programme was focussed at the same time on possible improvements in practice, research, education and administration; the entire life of the Programme as an organization reflected, in a small scale, the general development of nursing (Ashley, 1976; Fitzpatrick, 1983; White, 1978).

In conclusion, through its very nature, the final organization did provide a support system for the Nursing Programme. The authority of the health authorities was transferred to the Nursing Programme. Thus, it was possible, in working with the health centres and hospitals, to use as a reinforcement the involvement of the National Board of Health. Therefore, its sheer existence was enough to provide support. However, it was even more important that the Nursing Programme as an institution provided a vehicle for nursing advancement. The Programme as a framework for national and international collaboration was significant in terms of the objectives set by the nursing profession. It cannot be denied that the political decisions which brought about the Nursing Programme, were important. It would, however, be premature to ignore the paradoxical nature of the organization which represented various authorities having an impact on nursing.

Postscript Any such support system which would be comparable with the Nursing Programme and which would integrate nursing developments with the

government actions, does not exist. However, the dynamic lower level of the organizational hierarchy has got its successor. The development of nursing continues as a grass-root level movement within which nurses as a professional group are innovators and initiators of change.

Support provided by the organization to the process of the research and development Paradoxically, the organization of the Nursing Programme exhibited both supportive and obstructive tendencies. The official steering system which linked the Nursing Programme with the government provided crucial support to the Programme by its mere existence; with that authority, health centres, hospitals and schools were approached. That the steering system did not follow with any reasonable logic the major intentions of the Programme and seemingly made some unfavourable decisions, is very evident. In that respect, the support was questionable. The official structure, its unsupportiveness and its harmful decisions in matters of crucial importance to nursing, were the lessons that had to be learnt.

The question about financing the Nursing Programme is on the whole somewhat contentious. Taking into account the fact that the steering system of the Programme declared that one of its major tasks was to guarantee necessary resources for research and development, one may ask, was that support available to the Programme or rather, was the Programme controlled by control of resources? Resources in terms of financial support were minimal compared with the effort required for the Programme implementation; but that there anyway was some finance for nursing research projects in Participating Centres may be considered as a good start for continuous work in that area (i.e. research and development in nursing). It has been noted earlier that it may have been an unwise and too modest policy that the Nursing Programme was implemented as an integral part of the everyday work. That kind of policy did not necessarily justify claiming additional resources. This resulted in two things: nurses in Participating Centres had to work under great pressure, but on the other hand, it brought about a very powerful evidence of novel ways in using existing resources. That is one of the major outcomes of the Programme. In regard to the Centre of the Nursing Programme, it is argued that it was a real limitation to the Programme operations that a team of full-time workers was not established as planned.

An almost complete lack of support can be identified in several matters of crucial importance to nursing and to the purpose of the Programme. Those matters were on the agenda for years, and they would have required long-term planning, systematic monitoring and development. There was no evidence in the archival material which would have shown that the major issues would have been pursued systematically. This lack of organizational comprehension left questions about the purpose of nursing, nursing language, nursing education and administration unanswered. The very last effort of the steering system, i.e. the recommendations to the government authorities, was too weak or it came too late to remedy the accumulated problems.

Postscript The status of nursing as a discipline and profession still is an open matter, even an issue in society. Support to the continued efforts to follow the international developments in nursing, comes from the organized profession of nursing, and this support is benefitting from the national and international networking which started with the Nursing Programme. It seems evident that nurses themselves work 'in the spirit of self-reliance and self-determination' (WHO/UNICEF, 1978, p 3) and do not necessarily expect special support from the health or educational authorities. By means of supervision, consultation, continuing education and international contacts, nurses themselves have made the effort to provide support. This does not mean, yet, that nurses are passive in regard to the developments in the national health policy.

Characteristics of nursing at the completion of the Programme From the point of view of nursing, there was an internal logic in the forming of the focus of the Nursing Programme. For example, concerns identified in nursing and found in the context became ingredients of the Programme. It is regarded as a positive factor that the Programme provided a vehicle by means of which problems encountered in nursing came to light. The issues identified in the nursing practice settings at the beginning of the Programme, summarized as they are, reveal one important matter: the accumulation of the issues and problems did not concern only nurses but they clearly had an impact on patients' and clients' situations and on their health and well-being. The interpretation is made that the problem identification in the final reports indirectly indicated a lack of nursing. This is one dramatic outcome of the subordinate position of nursing.

There is no reason to believe that only the Participating Centres presented those problems, rather, it can be assumed that similar concerns have been common also in other nursing situations. In a medically dominated health care system these concerns were invisible because they existed outside the domain of medicine and there were no means by which they could have been handled. This is a perspective from which it can be understood that the nursing movement as a whole or a singular intervention of a nurse manager can not be diagnosed only as a powereagerness. The perspective which nurses are able to provide to health promotion and prevention, and to health and illness care, is invaluable and different from that of medicine.

The analysis suggests that the Nursing Programme with its content was very much in line with the prevalent health policy and there were achievements in the priority areas of this policy (cf. Table 4.1.). The Programme had already identified items which became more analytically approached as a part of the 'Health for All' movement. Though there were deficiencies observed by patients and clients and nurses themselves, there was also progress towards humane, holistic, interactive, systematic and collaborative approaches. Directed by the changes in the practice, the administrative system began to seek measures to support nursing. Progress made was not based on additional resources in terms of manpower but existing resources were reoriented by support measures such as inservice education and supervision.

It was significant that nurses formed, at the local and clinical level, the most innovative and creative entities. New concepts and practices were introduced in nursing, they were tried out, and gradually became a part of everyday practice. From the perspective of patients and clients, the efforts to provide participation and to make nursing more individual, systematic and comprehensive seemed to be steps towards positive direction. Research as an integral part of nursing - not belonging only to academia - began to evolve as a result of the impulse given by the Programme. It is argued that in the position such as nursing has in society, the experience and the informed intelligence at the clinical level is even more important than in an administratively favourable situation. Though the Nursing Programme demonstrated that the existing resources can be employed in new ways, there was not any official response which would have put the outcomes of the Programme to a wider use. Had that kind of

interest and support been available, nursing would have become a powerful force for better services.

Taking into consideration the paradoxical nature of organizations, it was not realistic to expect sudden and pervasive changes in the position of nursing or in its essential content. On the other hand, the professional agenda - which appeared in the planning phase of the Programme - was legitimate when compared with the international developments in nursing, or with the concerns identified but not attended to in nursing. It was not kept as a secret that even the European Programme was targeted towards establishing nursing's position, to facilitate health services and towards appropriate use of nursing's resources in terms of manpower, knowledge and skills. It is quite probable that the effort was over-ambitious, and if organism metaphor is employed in this connection, a too big change was attempted in one part of the system, and the rest of the system and the environment reacted negatively. This relationship between nursing and its environment seems to be significant and some future policies can be related to that.

The concerns, problems and deficiencies identified in nursing at the beginning of the Programme, presented an ethical dilemma which nurses were unable to solve. These ethical issues existed on the level of the health service system or even on the level of society, whereas ethical matters discussed by nurse authors related to the everyday practice of nursing and in principle remained within the accountability of a nurse (Davis & Aroskar, 1983). Through the Programme, the ethical foundation of nursing was successfully introduced in practice. The process of values clarification led to the identification and documentation of nursing principles and they in turn began to shape nursing practice and the nursing environment. The results showed that the common ethical heritage was acknowledged (Lanara, 1981; Steele & Harmon, 1983). Furthermore, the ethical underpinnings of the 'Health for All' programme, such as equity, self-reliance, self-determination and full participation of those served (WHO, 1986; WHO/UNICEF, 1978) were identifiable in the principles which also resulted in practical implementation, for example, through quality assurance procedures. It is argued, that not only the nature of nursing as a human service to people, but also the 'incomplete' position of nursing, will require the firm ethical bases which these principles provide.

The theoretical foundation was most probably providing orientation and intellectual stimulus to development: metaparadigm concepts of nursing were utilized, nursing theories were explored, the nursing process became a method for nursing practice and nursing practice, education and administration were developed accordingly. It is contended that the fact that nurses were utilizing the common knowledge base of nursing, to a certain extent validated their efforts. One gap between the Finnish and international development was recognizable. That was a failure in systematic use of earlier research findings. This is generally considered as a problem requiring special attention (Haller et al., 1979; King et al., 1981).

These two areas - ethical and theoretical foundations - had important integrative functions in the professional development: they provided a framework for analysing and organizing nursing work, but they also integrated national efforts and discussions in broader developments in the profession of nursing. In contrast to the official structure of the Programme, it is evident that the brain-like functioning of nurse participants - through the discussion and implementation of the metaparadigm concepts on a very basic level - established a contact point to the nursing knowledge base and their products added to the body of knowledge in nursing.

It can not be argued that the Nursing Programme was the only impetus for change. In the Participating Centres some dynamics existed before the Programme and there were changes in the educational system. It has also been pointed out that earlier national discussion had created some kind of general awareness among nurses about matters requiring consideration. However, the amount of accumulated problems was evident. Opportunities or established practices did not exist which would have solved the problems smoothly. This is related to the legal position of nursing and to the lack of autonomy which was discussed in the accounts of the Contact Persons. Indeed, lack of the explicitly stated function of nursing and lack of legal support have created a situation which can not be satisfactory to any parties involved. The position taken by the Contact Persons in regard to the general status of nursing seems to confirm what was observed about the steering system of the Nursing Programme: it exhibited at its best an unsupportive orientation as did the environment of the Contact Persons. The accumulated problems documented in the final reports justify, as one major solution, a more autonomous position of nursing in the health service systems.

Postscript Work for nursing has continued within the profession of nursing. The theoretical basis of nursing has been further explored. Through published guidelines, education and supervision more and more nurses have become skillful in producing quality assurance programmes. Community based nursing practice has been promoted, and primary nursing as a truly professional model for nursing is widely implemented. In several projects, nurses have continued to demonstrate how research can be integrated in nursing practice.

The overall objectives of the Programme and the actual outcomes The Nursing Programme accepted a wide range of challenges and tasks mentioned earlier as issues in nursing. None of them were irrelevant. Yet, taking into consideration the position of nursing in society, resources in use of the Programme and the scope of the tasks, this project first gave the impression of being overambitious. If an attempt is made to build a total picture of the concerns in nursing expressed in the European Programme and in the Finnish Programme, and in the context and in the Programme itself, the following picture will emerge. Concern about the nature of nursing and its contribution to people's health and society was expressed on the European level, in the contextual material of the Programme, and in the Programme itself. Nursing education and its future direction was identified as an area of interest or great concern by different parties: developing nursing education was one objective of the European Programme; it was a priority area identified by both the health and educational authorities in Finland; it was mentioned as a contextual variable and it was a priority area in the Nursing Programme. Organization and management of nursing services was one of the four major focuses of the European Programme, it was a priority area identified by the Finnish health authority, and it was a topic believed to require attention in the Nursing Programme. Nursing personnel systems and division of labour were identified as problems and/or target areas both in the European Programme and in the Finnish Programme. Finally, nursing concepts and nursing language were believed to require special attention in the Finnish Programme. Those five themes were consistently documented in a variety of sources and nursing literature supports the relevance of those themes (e.g. Hall, 1980; Stevens, 1984; Styles, 1982). Work in the schools and clinical settings addressed these issues in a significant manner. They were, however, not observed systematically by the decision-makers of

the Programme. The Finnish situation - in its endeavour to identify nursing - had great similarity with the circumstances which Johnson (1968) encountered and Armiger (1974) was commenting on.

There is nothing new or suprising in the overall reaction towards nursing as it appeared in the Programme. On the nurses' part, a constant drive for better education, professional autonomy, and attempts to advance nursing practice, have been recognizable. A lack of autonomy or lack of a reasonable share in decision-making have been major concerns in nursing (Fawcett, 1980; Garling, 1985; Lovell, 1980; Maas & Jacox, 1977). Year after year the subordinate position of nursing has been justified by all parties who have the decision-making power. With their diplomacy and interpersonal skills, nurse managers were fulfilling their roles - as was the case already with Miss Nightingale (Palmer, 1983). From the side of the health authorities, almost invisible obstruction and lack of interest can be identified. Nurses have been given only partial recognition. History is repeating itself. This study has shown the most significant outcome which the subordinate status of nursing has in society, and that is lack of nursing, or poor quality nursing. In the deepest sense, it is an ethical issue: the needs exist and the resources exist, but the age-old administrative practices prevent rational functioning.

It can be concluded that even a massive intervention, such as the Nursing Programme, which formally involved all important parties inevitably produced only partial advancement. Moreover, it is a significant observation - justified on the bases of archival sources - that the health authorities ignored what had been achieved and the progress made. There was clear evidence in the final reports to suggest that a more favourable clinical environment for practice was established by nurses and essential positive changes were made in nursing practice.

Postscript Even after the completion of the Nursing Programme the nursing profession faces similar concerns as those mentioned above. There is, however, a major change recognizable. The profession has moved to a more responsible and active internal collaboration for continuing development of nursing.

6. Recommendations

Development in nursing In this study it was shown that international development in nursing was an ingredient of the national development. Nurses as a resource for the health of people demonstrated readiness and up-to-dateness in regard to the general direction of the profession and in regard to the health policy adopted by the country. It was also shown that in the areas of ethical and theoretical foundations of nursing, the Programme operated by involving nurses in various roles and by creating collaboration through networking. In order to maintain and promote positive development in nursing, it is recommended that:

- (1) leadership function on the areas of nursing practice, education and research be strengthened
- (2) professional communication and the flow of information pertinent to nursing is continuously made possible and accessible to nurses.

The first recommendation implies in depth analysis of leadership qualities and functions, identification of leadership potential in practice, education and research, and facilitation of the growth of this potential. The second recommendation includes strengthening and enlarging the existing networks and special concern with professional language in Finland because it is the vehicle of communication.

The context of nursing in Finland It is important in nursing to become better acquainted with the social realities and for quality of care and service to people it is equally significant to be able to channel professional aspirations to goal-directed functions. Both of these aims require special knowledge and skills. In order to empower nurses to act for the good of people, to face social realities and to cope in various organizational environments, it is recommended that there be:

- (1) a provision of opportunities for nurses to acquire knowledge and skills to read and understand organizations and to organize professional actions accordingly
- (2) an enhancement of communication between the nursing profession and government authorities with special emphasis on the nature and purpose of nursing as a service to people.

An interactive process among nurses and health care administrators and nurses and government representatives is needed to prevent the accumulation of problems in nursing services and to make possible the use of potential developed in nursing. On the level of the nursing profession in Finland, the ability to read and understand organizations promotes the work of nurses as an organized profession.

Nursing practice, education, research and administration

Coordination of nursing practice, research, education, and administration were all concerns of the Nursing Programme and their continuing coordination and development are crucial. Based on the findings of the study it is recommended that:

- (1) clinical practice and its advancement continue to be the primary concerns of nursing and resources are allocated accordingly
- (2) a continuing education system is further developed through professional and government efforts for ongoing transmission of nursing knowledge
- (3) knowledge development and the promotion of various patterns of knowing in nursing be investigated
- (4) epistemological and ontological questions in nursing be addressed
- (5) integration of research into all aspects of nursing be supported by educational, administrative and financial means
- (6) ongoing analyses of nursing development in Finland be made
- (7) brain-like organizations be developed and facilitative approach to nursing management be utilized.

In this study the development of nursing in Finland was analysed and evaluated. Challenges to nursing were described and outcomes of the major collaborative effort were featured. It was shown that nursing has great potential

to contribute to people's health. This study, through the analysis of seven years development in Finnish nursing, is only just a beginning of what can be.

APPENDIX ONE

QUESTIONNAIRE TO THE NURSING PATIENTS AND CLIENTS

This questionnaire is translated from Finnish without language validation. The version given here applies only to hospital inpatients. In the original, variant wording was given where necessary for domiciliary care patients.

The form was filled in by

1) the patient/client alone _____

2) patient/client assisted by a relative _____ (information given by a Contact Person)

Instruction: Please answer the questions by ticking or writing your answer in the space provided.

1. Your year of birth: _____

2. Your sex: () female
() male

3. How often in the past have you been in hospital?

3.1. () This is my first experience of being cared for in hospital

3.2. () I have seldom been cared for in hospital

3.3. () I have often been cared for in hospital

4. How long have you been in hospital this time?

4.1. () Three days or less

4.2. () Less than a week

4.3. () 1-2 weeks

4.4. () Over two weeks but less than a month

4.5. () Over a month but less than six months

4.6. () Six months or more

5. What was the reason for coming to hospital this time? Please write your answer here:

6. In what way did nurses become acquainted with your case when you were admitted to hospital this time?

	Yes	No	Can't say
6.1. Did you have a discussion with a nurse concentrating on you/your case?	—	—	—
6.2. Did that nurse choose to ask conventional formal questions in familiarizing herself with your case?	—	—	—
6.3. Were all the matters significant to you opened up at the beginning of your hospital stay?	—	—	—
6.4. In discussion with the nurse, were there matters you did not consider important?	—	—	—
6.5. Was your care based on your own experience of your own illness?	—	—	—
6.6. Did you get the impression that the nurse did not make any special efforts to familiarize herself with your case?	—	—	—

7. Please describe what matters were discussed with nurses when you came into hospital this time.

7.1. What matters related to yourself and your way of life were discussed?

7.2. What matters related to your health or illness were discussed?

7.3. What matters related to your health care or illness care were discussed?

8. The following three questions concern discussions you had with nurses at the time of your admission.

	Yes	No	Can't say
8.1. Were you given the opportunity to express your feelings and experiences?	—	—	—
8.2. Were interest and empathy shown in dealing with health- and illness-related matters?	—	—	—
8.3. Was your introduction to your health and/or illness care handled as a formal routine?	—	—	—

9. How did nurses involve you in planning your own care?

	Yes	No	Can't say
9.1. Were you encouraged to be responsible and make decisions?	—	—	—
9.2. Did you receive an explanation of the principles on which your care was based?	—	—	—
9.3. Were you properly informed about options in your care?	—	—	—
9.4. Was your opinion asked about the care to be given?	—	—	—
9.5. Was your opinion taken into account?	—	—	—

10. As you experienced it, what were the aims of the nursing staff in giving you care?

	Yes	No	Not applicable	Can't say
10.1. Did they aim at the completion of investigations?	—	—	—	—
10.2. Did they aim at treating of a disease?	—	—	—	—
10.3. Did they aim at increasing your knowledge about health?	—	—	—	—
10.4. Did they aim at promoting a feeling of well-being?	—	—	—	—
10.5. Did they aim at improving family relations and/or relationships with significant others?	—	—	—	—
10.6. Did they aim at clarifying the nature of your work and related responsibilities?	—	—	—	—
10.7. Did they aim at good physical care?	—	—	—	—
10.8. Did they aim at giving medication regularly?	—	—	—	—
10.9. Did they try to support you in coping with your situation created by the problem you mentioned in question 5?	—	—	—	—
10.10. If none of the above seemed to be their objectives what do you think they were aiming to do?				

11. What were your own expectations? Describe your expectations here:

12. During this hospital stay, did the nursing care include elements of personal hygiene such as:

	Yes	No	Not applicable	Can't say
12.1. Nutrition	—	—	—	—
12.2. Regularity of bowel movements	—	—	—	—
12.3. Physical exercise and how to plan it	—	—	—	—
12.4. Sleep and rest	—	—	—	—
12.5. Skin care	—	—	—	—

12. Did the nursing care include measures which were related to preservation of one's well-being and stimulating the mind through provision of information, such as

12.6. Relieving fear and anxiety	—	—	—	—
12.7. Providing health information	—	—	—	—
12.8. Matters related to growth and development	—	—	—	—
12.9. Relief of pain	—	—	—	—
12.10. Providing mental stimulus	—	—	—	—
12.11. Protecting one's privacy	—	—	—	—

12. Did the nursing care include measures which were concerned with relationships with other people and the environment, such as

12.12. Your family situation	—	—	—	—
12.13. Human relationships	—	—	—	—
12.14. Relationships between the sexes	—	—	—	—
12.15. Relationship between work and health	—	—	—	—
12.16. Safety of the immediate environment	—	—	—	—
12.17. Maintaining relationships with relatives, friends and acquaintances	—	—	—	—

13. Please describe what kind of matters did nurses help you with.

13.1. If nurses did something on your behalf, what was it?

13.2. If nurses helped you by teaching and guidance, what was it?

13.3. If nurses helped you by mental and/or physical support, in what way?

13.4. If nurses helped you by altering your environment (either with regard to human relationships or physical surrounding), what did they change?

14. Please compare items presented on the same line. Which one was given importance by the nursing staff. Please answer by ticking the most important item.

As you saw it, did the nurses give importance to

14.1. patient's dependence on staff ()	or	patients taking responsibility for care ()	or	both equally important ()
<hr/>				
14.2. making decisions on behalf of the patient ()	or	patients making autonomous decisions ()	or	both equally important ()
<hr/>				
14.3. maintaining the routine of the institution ()	or	observing the wishes of individual patients ()	or	both equally important ()
<hr/>				
14.4. patients taking collective initiatives for themselves ()	or	channelling everything through the staff ()	or	both equally important ()
<hr/>				

15. Please assess if you got enough information in hospital about the following topics to form the basis of your own care:

	Yes	No	Can't say
15.1. about the nature of your illness	—	—	—
15.2. about care at home after discharge from the hospital	—	—	—
15.3. about the impact of illness on your work	—	—	—
15.4. about points of contact with health services	—	—	—

16. Have the nursing staff made sure that your home environment is prepared to receive you?

- () yes
() no
() can't say

17. During this hospital stay, have you learnt anything new which will help and encourage you to cope with your personal health care better than before?

- () no, I did not learn anything
() yes, I learnt something
() difficult to say

17.1. If you answered "no, I did not learn anything" to the previous question, please write down what you would have wished to learn:

17.2. If you answered "yes, I learnt something" to the previous question, please write down what did you learn:

18. Please describe here how your personal expectations and wishes were fulfilled during this hospital stay?

Please check that you have answered every question. THANK YOU.

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